THE STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
WASHINGTON STATE MEDICAID

Inpatient Reimbursement System Study

Phase 1 Report

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Introduction

During the 2005 Washington State legislative session, Senate Bill 6090 mandated the Department of Social and Health Services ("DSHS") to procure a contractor to conduct an independent analysis of the current system for establishing hospital inpatient payment rates for services provided to the Medicaid population, and to submit recommendations for improvements to the current inpatient hospital reimbursement system. The purpose of this study was to inform State policymakers and lawmakers as they seek to identify and evaluate suitable enhancements to the current system.

DSHS awarded a contract to Navigant Consulting, Inc. ("NCI") in August 2005 to conduct this study. Generally, the scope of this project, which is described in more detail later in this report, was to conduct an evaluation of the strengths and weaknesses of the existing fee-for-service ("FFS") Washington Medicaid inpatient reimbursement system, conduct a survey of other states' Medicaid reimbursement systems and make recommendations for potential changes to Washington's system. This process comprises Phase 1 of the project. The purpose of this report is to describe the results of this evaluation, and to present our recommendations.

The recommendations described in this Phase 1 report should be considered as preliminary. We have prepared recommendations without the benefit of a comprehensive fiscal impact model, which will be a key component of Phase 2 of this project. It is not possible at this point in time to understand with any certainty the fiscal impacts of the recommendations on the State and on the hospital providers, and it would be inappropriate to finalize decisions regarding our recommendations without the benefit of such an analysis.

It is also important to understand that one of the key directives given by DSHS for this project is that any changes to be implemented by DSHS resulting from this study must be budget neutral. In other words, payments in the aggregate resulting from the modified payment methodology must be equal to what payments would have been if the current payment methodology remained in place without change. Changes in the payment methodology may result in some sifting of payments between individual services or individual providers, but in the aggregate, payments must remain the same.

Finally, this study is not intended to evaluate the adequacy of funding for inpatient hospital services under the Medicaid (Title XIX) FFS program. While the analyses described in this report present information regarding payments received by hospitals, and estimates of the costs they have incurred, an evaluation of the adequacy of funding must consider many other factors which are simply outside of the scope of this project. At the same time, it is important to understand that it is not our intent as part of this study to identify ways to reduce payments to hospitals in the State through modifications to the payment methodology.

In Phase 2 of this project, which will begin in December 2005, NCI consultants will carry the Phase 1 recommendations forward and conduct additional financial analyses and fiscal impact modeling to evaluate the impacts of the potential system changes. Based on these Phase 2 analyses, NCI will make final recommendations for changes to the system, and assist DSHS with implementing the changes.

We will finalize the recommendations in Phase 2 of this project, to a significant extent, based on the projected fiscal impacts to the State and the hospitals. It should be noted that many, if not all of the recommended methodology changes will be interdependent. In other words, recommendations or methodology changes should not be accepted or rejected individually. Making changes to some of the payment methodology features will be dependent upon other recommended changes. Accepting some, but not all recommended changes may result in unintended consequences, which might include not achieving budget neutrality, creating inappropriate incentives for providers and making payments that are not equitable.

Phase 1 Overview

In Phase 1, NCI consultants conducted a qualitative analysis of the current system based in part on comparisons to current practices of other states' Medicaid Programs, as well as our consultants' expert knowledge of payment systems for these programs and commercial payers. We enhanced our qualitative analysis through a comprehensive quantitative analysis of trends in utilization, payments, charges, estimated costs and acuity data for State Fiscal Years[1] ("SFY") 2002, 2003 and 2004, for all hospitals participating in the Medicaid Program in Washington State. Also, we received input from providers and other stakeholders, and considered this input as part of the evaluation process and formulation of potential recommendations.

In Phase 1, we examined the following areas and issues:

- The current Diagnosis-Related Group ("DRG")-based[2] payment methodology, including methods used to determine payments and rates under the methodology,

[1] The Washington State Fiscal Year is the 12-month period ending on June 30th of each year. For example, Washington's SFY 2002 is the period from July 1, 2001 through June 30, 2002.
[2] The term "DRG-based" is used generically throughout this report to refer to the prospective payment methodology that relies on a patient classification system, or grouper, to assign a payment to each inpatient discharge. Payment is generally determined by multiplying a fixed base rate, or conversion factor, by a relative weight, which is unique to each patient classification.

- Determining payments for services using a Ratio of Cost-To-Charges ("RCC") methodology[3],
- The potential use of other payment options, such as a fixed per diem amount or fixed per case amount,
- The methodology used to identify outliers and make outlier payments for extraordinarily high cost cases,
- The appropriateness of allowing payments for individual claims under the current DRG-based methodology to exceed allowed billed charges submitted by the hospital for the claim,
- The methodology used to pay for psychiatric services provided in inpatient hospital settings,
- The current selective contracting program,
- The current centers of excellence program,
- The current critical access hospital payment program,
- The current trauma payment program, and
- Historical trends in utilization, charge and payment data.

We have described our detailed approach to this examination in the following sections of this report. We have also presented recommendations resulting from this examination.

It should be noted that this study focused exclusively on reimbursement methods for inpatient hospital services. We did not examine reimbursement methods for outpatient hospital, physician, home health, skilled nursing, hospice or other types of services as part of this study.

Project Team

Navigant Consulting's project team comprises three of the nation's leading Medicaid prospective payment system experts. Catherine Sreckovich, who has been assisting Medicaid programs with hospital payment systems for more than 20 years, is the Project Director. As project director, Ms. Sreckovich has ultimate responsibility for supervision of all tasks, and generation of all project deliverables.

Washington Medicaid currently uses the All-Patient Diagnosis Related Group, or AP-DRG patient classification system.

[3] Under an RCC payment methodology, payments are generally determined on a claim-by-claim basis by multiplying a claim's allowed billed charges by the facility's RCC.

Jim Pettersson, from our Seattle office, is serving as the Project Manager. Mr. Pettersson has been assisting Medicaid programs with hospital payment systems for 15 years. He has responsibility for managing all project tasks on a daily basis. He has also coordinated and supervised the preparation of all deliverables. Mr. Pettersson is serving as the main point of contact for the State.

Dr. Henry Miller, who has been assisting the Medicare program, Medicaid programs and commercial payers with hospital reimbursement systems for more than 25 years, is serving as the leader of the project's Policy Analysis Team. Dr. Miller is also serving as a Technical Advisor for all project components.

All three of these consultants have extensive experience with the design, implementation, evaluation and modification of inpatient hospital prospective payment systems, and in particular, DRG-based systems.

Other experienced health care consultants consisting of policy and data analysts, several of whom are also located in our Seattle office, are supporting, and will continue to support this project.[4]

Stakeholder Input

As mentioned previously, we received input for this project from various stakeholder groups, facilitated by DSHS and the Washington State Hospital Association ("WSHA"). We met three times with the WSHA Inpatient Hospital Advisory Committee, which is made up of representatives from a cross-section of hospital types. We met initially with this group to discuss the project scope and approach, and then again to discuss our progress with Phase 1. During this second meeting, we also received significant input from the providers regarding their concerns related to the current inpatient hospital payment system, potential changes to the system and other related issues. In the third meeting, we presented our Phase 1 draft report and recommendations to the group, and received their comments. We provided the Phase 1 draft report to WSHA prior to the third meeting, and WSHA distributed copies of the draft report to the Committee members prior to that meeting.

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[4] Navigant Consulting is a publicly owned national consulting firm with more than 35 offices located across the United States and abroad, and with an office in Seattle that serves as a base for 35 consultants. Our professionals have multi-disciplinary backgrounds, including Certified Public Accountants, Certified Management Accountants, Registered Nurses, Certified Fraud Examiners, Public Policy specialists, Information Technology Specialists, and Engineers, among others. Navigant Consulting's healthcare practice professionals have successfully completed healthcare engagements in virtually every state, for Medicaid and other state agencies, as well as numerous providers, provider groups, commercial insurers and managed care organizations.

We also met separately with the Critical Access Hospital Subcommittee and the Psychiatric Subcommittee to discuss the current payment system related to services provided by these two groups.

The WSHA also provided us with a document entitled "Principles for Medicaid Payments to Washington Hospitals", which was created by the WSHA Inpatient Task Force. This task force is made up of chief executive officers from member hospitals that provide significant levels of inpatient care to Medicaid eligibles in the State. This document summarizes the providers' guidelines that they would like to State to consider as the State moves forward with modifying its inpatient payment methodologies. This document was considered by the Project Team as part of this study. A copy of this document is included in Appendix G to this report.

After our third meeting with the WSHA Inpatient Hospital Advisory Committee, the WSHA Medicaid Inpatient Task Force held a meeting to discuss our preliminary report and recommendations. This Committee prepared a formal response to the State regarding the draft report. A copy of the response is included in Appendix H of this report.

The State also prepared a letter commenting on the WSHA Inpatient Hospital Advisory Committee response, which is included in Appendix I of this report.

Input received from all parties has been considered as part of our evaluation of the current system, and the formulation of our Phase 1 recommendations.

Report Organization

This Phase 1 report is organized into the following sections:

- **Qualitative Analysis**. In this section, we describe our analytical approach to evaluating the current Washington Medicaid inpatient hospital reimbursement methodologies, and the results of our comparisons to other states' methodologies. We describe how states were selected for comparison, the survey questions used to gather information, how we completed the state surveys, the evaluation criteria used to select exemplar states and the results of our evaluations.
- **Quantitative Analysis**. In this section, we describe our comprehensive trend and other analyses of SFY 2002, 2003 and 2004 paid claims data. We describe the process for receiving and uploading the data, adjustments made to the data, the analyses completed and significant observations resulting from the analyses.

- **Phase 1 Project Findings and Recommendations**. In this section, we provide an overview of our significant findings and recommendations resulting from our Phase 1 evaluation. We present our findings and recommendations by topic area. It should be noted that many of the recommendations provided in this section should be considered preliminary, and should be evaluated further as part of Phase 2 of this project.
- **Report Appendices**. The analyses completed for this Phase, both qualitative and quantitative, are significant. In the Appendix section of this report, we provide all of the supporting documentation and analyses generated during Phase 1.

Qualitative Analyses

For this component of Phase 1 of this project, NCI examined the inpatient hospital payment methodologies of several states, evaluated their methodologies, and compared them to the methodologies used by Washington Medicaid. In some instances, we included references to the Medicare methodology when, in our judgment, we believed that the Medicare approach was relevant.

For purposes of this process, we identified two groups of states for comparison: a group of 10 "core" survey states, and additional "supplemental" states. We selected and examined the "core" survey states for purposes of evaluating DRG-based reimbursement issues, such as the high cost outlier policy, the methodology used to calculate hospital conversion factors and the use of RCCs. We selected and examined "supplemental" survey states to assist in our evaluation of some of the non DRG-based issues, such as selective contracting and the trauma payment program. We discuss our selection of "core" survey states and "supplemental" survey states separately in the following sections.

Preliminary Research

Prior to the selection of survey states, we conducted significant internet research to identify state Medicaid programs that reimbursed for inpatient hospital services using a DRG-based methodology. This research included information from approximately 25 states.

We gathered information related to the DRG-based approaches for each of these states, for example, the type and version of the DRG grouper used, the use of RCCs, the use of per diem payments, if and how peer groupings were used. This information was used as a starting point for the surveys and evaluation matrices that are described later in this section.

"Core" State Selection

Navigant Consulting selected the following 10 "core" states for purposes of this analysis:

- Illinois
- Indiana
- Nebraska
- New Jersey
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Virginia
- Wisconsin

Navigant Consulting analyzed the following criteria and statistics to select these "core" states[5],[6]:

- **Total Population** (FY03) – This variable is the total count of state residents. The source is the Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Estimates are based on pooled March 2002 and 2003 Current Population Surveys.

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[5] Note that criteria and statistics analyzed for this process were from varying time periods. In all instances, the data examined were the most current data available to us at the time of the analysis.

[6] Navigant Consulting also considered the following variables in its comparison of state Medicaid programs. However, we did not include these variables in the actual "core" selection methodology because the significance of these variables was deemed secondary to those variables already described. Additionally, preliminary analyses revealed that even if these secondary variables were considered, the selection results would not vary from those presented.

- Medicaid Spending by Service (FY03);
- Medicaid Spending on Acute Care (FY03);
- Medicaid Spending on Long term Care (FY03);
- Medicaid Payments by Enrollment Group (FY01);
- Medicaid Payments per Enrollment Group (FY01); and
- Federal Matching Rate (FMAP).

- **Total Medicaid Enrollment** (FY03) – This variable is the total count of state Medicaid recipients. The enrollment estimates differ slightly from similar estimates posted by the Centers for Medicare and Medicaid Services (CMS) because adjustments have been made for several states where some individuals appeared to be categorized incorrectly. The source is the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from CMS, 2005. Enrollment estimates are rounded to the nearest 100.

- **Total Medicaid Expenditures** (FY03) – This variable is the total dollar amount (state and federal expenditures) allocated to the state's Medicaid program. Expenditures include benefit payments and disproportionate share hospital payments; they do not include administrative costs. The source is the Urban Institute estimates for the Kaiser Commission on Medicaid and the Uninsured, based on Form 64 from CMS, 2004.

- **Total State Medicaid Expenditure** (SFY03) – This variable is the total amount of state-only dollars spent on the Medicaid program. Data are for SFY 2003 and include the General Fund and Other State Fund expenditures. All years reported are state fiscal years unless otherwise indicated. In each of the proposed states the fiscal year begins on July 1 and ends on June 30. The source is the National Association of State Budget Officers, *2003 State Expenditure Report*.

- **Medicaid Expenditure per Enrollee** (FY01) – This variable is the total dollar amount (state and federal expenditures) spent on each Medicaid beneficiary for a given year. These figures represent the mean level of payments across all Medicaid enrollees. Spending per enrollee does not include disproportionate share hospital payments (DSH). The source is the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from MSIS reports from CMS, 2005.

- **Medicaid Expenditures Annual Growth Rate** (FY1991 - 2001) – This variable is the annual growth rate in expenditures for state Medicaid programs, averaged over the period of 1991 to 2001. All spending includes state and federal expenditures. Growth figures reflect increases in benefit payments and disproportionate share hospital payments, but do not include administrative costs or accounting adjustments. The source is the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on Form 64 data from CMS.

- **Total SCHIP Expenditure** (FY03) – This variable is the total dollar amount (state and federal expenditures) spent on the state's SCHIP program. The source is the FFY2003 SCHIP Expenditures from CMS, Special Data Request, 2005.

- **State Share of Total SCHIP Expenditures** (FY03) – This variable is the percentage of total SCHIP expenditure that the state allocates from its revenues. The source is the FFY2003 SCHIP Expenditures from CMS, Special Data Request, 2005.

- **SCHIP Growth Rate** (Dec. 2002 - Dec.2003) – This variable is the annual growth rate of a state's SCHIP enrollees, from December 2002 to December 2003. Note that Arkansas and Tennessee phased out their Medicaid expansion programs in September 2002. The source is the report of Health Management Associates' calculations for the Kaiser Commission on Medicaid and the Uninsured, using data as of December 2003, published July 2004.

- **Number of FFS Enrollees as a Percent of Total Medicaid Beneficiaries** (Dec. 2004) – This variable is the percentage of Medicaid beneficiaries in FFS programs, as opposed to managed care. These statistics were calculated by subtracting the managed care percentage from 100 percent. The source is the Medicaid Managed Care penetration rates by state as of December 31, 2004 from CMS.

Navigant Consulting gathered and analyzed the most recent statistics for the above identified variables for all 50 states and the District of Columbia. For each of the 10 variables, NCI arrayed the 50 states in order, and identified the 20 states (10 above, and 10 below) with the most similar statistics to the State of Washington. We then counted the number of variables for which each state met these criteria. Those states that had a score of 5 or more (meaning the state ranked closely to Washington across at least 5 of the variables) were selected for further analysis. We then examined this narrowed list of states to understand the Medicaid hospital inpatient reimbursement methodology for each state, and identified those states with a DRG-based methodology as our "core" survey states. This resulted in the selection of nine of the "core" states listed previously.

To round the sample out to 10 "core" states, we discussed alternatives for selection with the State Medicaid Project Team. Simply relaxing the criteria described earlier to add another state did not reveal a clear candidate for inclusion. Members of the State Medicaid Project Team suggested that we consider states that were closer in proximity to Washington, such as Utah, California or Oregon.

Based on our preliminary research of California, we found that the vast majority of Medicaid inpatient bed days in California are provided under a selective contracting waiver. We had already determined that California would be analyzed as one of our "supplemental" states with a particular focus on selective contracting issues. However, given the nature of their inpatient program, we did not believe that it would be productive to include California as a "core" state for purposes of this project.

We considered both Oregon and Utah as additional "core" states, and by using the same scoring criteria that was used to select the other nine "core" states, both states received the same score. However, we concluded that Oregon was the best candidate for inclusion in this analysis, based on the following considerations:

- Oregon is a neighbor to Washington, and has similar geographic characteristics, which include the urban population regions between the Pacific coast and Cascade Mountain Range, separating the western part of the state from the primarily rural population areas in the eastern part of the state. Oregon also shares the Interstate-5 corridor with Washington.
- Oregon's inpatient prospective payment system makes use of geographic adjustments for payments for services to recognize that the costs of providing services can be affected by geographic differences.
- Oregon takes into consideration border-area hospitals as part of its payment policies for out-of-state hospitals.
- Oregon has established an outlier policy that limits outliers to only those claims with extraordinarily high costs.

Other feedback from the State Medicaid Project Team indicated that we should be careful not to include only states that are similar to Washington, at the risk of overlooking a state that had developed a unique solution to some of the issues confronting Washington. This was an important consideration, and to address this issue, we relied on other research that had already been completed.

As part of our initial Internet research, we gathered high-level information on inpatient payment systems for approximately 25 states. We re-examined this information for purposes of identifying unique solutions that could be carried forward into our Phase 1 recommendations. We also applied our extensive and specific Project Team experience for this purpose.

"Supplemental" State Selection

In addition to the proposed list of ten "core" states to be included in our analysis, we identified several "supplemental" states to serve as comparative resources for some of the non-DRG payment methodology issues. We identified states with characteristics that were similar or related to the non-DRG issues to be examined as part of this study, and based on our preliminary research of state plan amendments, state rules and regulations, state website descriptions and other internet-based sources, we identified those that were most relevant for our study purposes. We have summarized this process by issue in the following paragraphs. States identified to be the most relevant for this study (in addition to the "core" survey states), which were included in our analysis, are identified in parentheses:

- **Separate payment methodologies for critical access hospitals** – (*Nevada)* Navigant identified four states that employ a unique payment methodology for critical access hospitals. Montana, Nebraska, Nevada and Kentucky use a cost-based payment methodology to reimburse critical access hospitals, while other hospitals in those states are paid prospectively. Nevada was determined to be the most appropriate choice because we evaluated Nevada's payment system with respect to other issues (enhanced trauma payments, and the use of per diems). In addition, Nebraska's payment methodology for critical access hospitals was also to be examined, as Nebraska was identified as a "core" state.

- **Enhanced trauma payments** – (*Nevada and Texas)* Navigant identified two states that provide enhanced fees for trauma cases. In Nevada, an enhanced rate of 1.63 times the regular medical surgical per diem rate is paid to Level I trauma centers for full trauma team cases. Texas has a somewhat unique program and does not fund trauma payments through the Texas Medicaid program, but requires that hospitals have a trauma facility designation to be eligible for DSH payments.

- **Use of a fixed per diem or fixed per case payment methodology** – (*Nevada and Louisiana)* Navigant Consulting identified 23 states that use a per diem payment methodology for some or all inpatient hospital services. Some states use prospective cost-based per diem rates, while others use systems based on prospective tiered rates, peer groups, or type of admission. Nevada and Louisiana were selected because both states use slightly different approaches to per diem payments that were of interest in our review. Nevada uses a prospective all-inclusive per diem by type of admission and Louisiana uses a prospective per diem based on peer groups.

We found only one state, Kentucky, that uses a fixed per case approach without the use of a DRG-type payment methodology. Kentucky pays for transplant services based on the lower of a fixed amount or billed allowed charges. No states were added for the fixed per case issue because such a methodology is virtually the same as a DRG-type payment methodology, and the DRG-type payment methodology is adequately addressed by all of the selected "core" states.

- **Use of selective contracting** – (*Texas, California)* Navigant identified several states that use selective contracting for one or more services. Some states use selective contracting for very few services (Colorado selectively contracts for transplant services only). California was selected because it has a broader selective contracting program. Texas was also selected, even though it recently discontinued its selective contracting program. While in place, Texas' program included almost all inpatient acute and psychiatric hospitals.

For all other issues that were part of this study, we relied on information gathered from the "core" states.

Development of Survey Questions

Navigant Consulting developed a set of more than 100 survey questions. These questions focused on gathering the necessary information to allow us to gain a comprehensive understanding of the survey states' methodologies. Some questions were intended to be very open-ended; some were very specific and targeted to address specific issues.

Navigant Consulting provided the survey questions to the State Medicaid Project Team prior to initiating the surveys. The State Medicaid Project Team provided suggestions for additions to the questions.

A copy of the survey questions are provided as Appendix A to this report.

Completing the Surveys

We initially answered the survey questions, to the extent possible, using research such as state plan amendments, state administrative codes, state rules and regulations and other publicly available information collected through the "core" state selection process. We also relied on our consultants' personal and first-hand knowledge of the selected states' approaches gained through previous and current consulting projects for those states.

If necessary, we conducted telephone interviews with "core" state representatives to address questions that could not be answered through our preliminary research, to confirm our understanding of their approaches and to gather more detailed information.

The results of our state surveys are provided in Appendix B to this report. It should be noted that these surveys are a working document, and are shown in Appendix B as of September 2005. In some instances, we have gathered more current information to supplement the surveys, and have recognized that additional information in the evaluation matrix format only, as described later in this section. We did not update the surveys since the evaluation matrices contain the most current information gathered from the exemplar states.

Scoring the Survey Responses

Using the completed state surveys, NCI consultants selected other states' reimbursement methodology features or components for purposes of comparison to Washington Medicaid's methodologies. These comparisons were documented in the evaluation matrix format, which is described in later sections.

We evaluated each of the "core" survey states' reimbursement approaches or features using a comprehensive set of evaluation criteria. This comprehensive list of evaluation criteria includes the most relevant variables such as those related to cost-effectiveness, generosity (and fairness) of reimbursement levels, ease of implementation and on-going administration, impact on access and quality of care.

It should be noted that the results of the systematic evaluation described in this section were not the sole determinant in the formulation of our project findings and related recommendations. Other variables were considered as well, including support for changes from relevant stakeholders, consistency with other relevant Washington State Medicaid policy, consideration of federal requirements and limitations, and the potential impact on other Washington Medicaid inpatient program features.

We developed and applied the following program evaluation criteria for this process. We grouped the criteria into those that relate to program impact and those that relate to ease of implementation. This categorization is also used in the evaluation approach we describe in the next section. The criteria are:

- **Projected impact criteria:**
  - Equity of payment among providers
  - Ability to recognize differences in hospital characteristics

- Ability to recognize differences in resource requirements
- Predictability and stability of resulting payments
- Incentives for providers to contain costs
- Incentives to promote access to care
- Incentives to promote high quality care

- **Ease of implementation criteria:**
  - Administrative burden placed on providers
  - Simplicity of program administration
  - Payment method supports consistency in billing and coding practices with other payers in the State
  - Impact on coding and billing practices with respect to accuracy
  - Impact on coding and billing practices with respect to efficiency
  - Consistency with other Washington State agencies

We evaluated each payment system feature or methodology option identified in our "core" state survey using all applicable criteria listed above[7]. We then assigned a numeric score to each option based on an overall assessment of its projected impact and its ease of implementation. We used the following scoring convention for this process:

Projected Impact

1 – Negative. This designation was assigned to payment system features that were projected to have an overall negative impact.

2 – Neutral. This designation was used for features that were projected to have an overall impact that is neutral.

3 – Positive. This designation was assigned to payment system features that were projected to have a positive overall impact.

Ease of Implementation

1 – Difficult to implement. This designation was used for payment system features that would require substantial investments in technology, time, money, training, or administrative changes to effectively be implemented.

[7] Some evaluation criteria were not applicable to every option being evaluated. For example, if evaluating the high cost outlier threshold policy, the evaluation criteria related to the administrative burden placed on providers would not have applied.

2 – Moderate. This designation was used for features that require moderate investments or additional resources to be effectively implemented.

3 – Easy to Implement. This designation was used for features that require few to no additional resources to be implemented.

Navigant Consulting evaluated and scored all features and methodology options from the "core" survey states using this scoring methodology. We used the results of this scoring to select the "core" states to include in the evaluation matrices. We also selected "supplemental" states for the evaluation matrices when, in our judgment, we believed their approaches to be relevant for consideration.

Selection of States for Evaluation Matrix

Using the results of the scoring and based on other considerations described earlier, NCI consultants selected the states to be included in the evaluation matrices. The figure below presents the states included for each issue or topic:

Figure 1: States Selected For Evaluation Matrix

Issue or Topic	Selected States or Programs
DRG Methodologies and Related Issues	Ohio and Pennsylvania
Per Case and Per Diem Payment Methods	Virginia, Indiana and Medicare
RCC Payment Methodology	Indiana and Ohio
High Cost Outlier Policy	North Carolina and Virginia
Critical Access Hospitals	Wisconsin and Ohio
Border Hospital Payment Methodology	Oregon and New Jersey
Psychiatric Services	North Carolina, Indiana and Medicare
Selective Contracting	California and Texas
Trauma Care	Texas, Pennsylvania and Illinois

None of the selected "core" states used the Centers of Excellence designation for purposes of reimbursement. This observation may be notable on its own. As such, the consulting team relied upon other information for the purpose of evaluating the Centers of Excellence approach and related recommendations.

Preparation of Evaluation Matrices

The final step in this process was the development of evaluation matrices. For each topic or issue, NCI prepared an evaluation matrix that described the methodologies used by Washington Medicaid, and the other states (or Medicare) selected as described above. In this evaluation matrix, NCI consultants compared and evaluated the options, provided a discussion of the strengths and challenges associated with each option, and presented recommendations for potential modification to the current Washington Medicaid methodology.

It should be noted that the recommendations provided in each evaluation matrix are not based solely on the information provided for the selected exemplar states in the matrix. While the selected states generally provided the best options for consideration, we did take all of the survey states' approaches and experiences into consideration as part of this process.

The evaluation matrices for each issue or topic are included in Appendix C to this report. The recommendations are also included in a separate section later in this report.

Quantitative Analysis

We conducted a comprehensive analysis of historical Medicaid paid claims data for SFYs 2002, 2003 and 2004, to support our analyses, and to support our resulting recommendations.

For this analysis, we examined allowed billed charges, payments, discharges, case-mix indices, and estimated costs, in the aggregate and on an average per discharge basis. We examined these elements at the aggregate statewide level, as well as by peer group, by facility, by AP-DRG classification, and by service area. We also examined these data elements by payment type, such as DRG-based payments, high-cost outlier-based payments, and RCC-based payments.

These analyses are presented in their entirety in Appendix D of this report. In the following sections, we provide a discussion of the key data considerations that should be understood to better understand the results of the analysis. We then present a brief description of each report contained in the analysis.

Data Considerations

We analyzed only fully adjudicated inpatient hospital paid claims data, delineated by dates-of-service for SFYs 2002, 2003 and 2004. We analyzed three separate datasets; Medicaid (Title XIX) FFS inpatient hospital paid claims data, General

Assistance-Unemployable ("GAU") inpatient hospital paid claims data, and Long-Term Acute Care ("LTAC") Hospital claims data. Our data excluded Healthy Options managed care paid claims, and therefore reflect only FFS paid claims. Our data also excluded other types of services, such as outpatient, home health, skilled nursing, hospice and physician services.

For purposes of this analysis, we examined allowed billed charges. These are the charges that are allowable under the State's current billing guidelines, and exclude charges for services that are not reimbursable under the State's current Medicaid State Plan (or under other State regulations for GAU and LTAC claims). To the extent that hospitals provided services and generated charges that are not allowable by the State, these are not reflected in the data.

Payments included in our analysis represent the maximum allowable payment under the current Medicaid State Plan (or State regulations), and include all third-party amounts that were reported as offsets to the State's obligation for payment. These payment amounts were extracted directly from the paid claims dataset for all hospitals except for critical access hospitals. Critical access hospitals are reimbursed by Washington Medicaid at 100 percent of their allowable costs through a "cost settlement" process. Because these cost settlements are not reflected in the paid claims data, we have assumed payments for these hospitals to be equal to their costs.

For purposes of this analysis, we estimated costs by multiplying the allowed billed charges for each claim times the RCC for the hospital that provided the service. We estimated costs using the RCCs for each hospital that were in effect during the mid-point of the SFY being analyzed. For example, for SFY 2004 data (claims with dates of service from July 1, 2003 through June 30, 2004), we used the RCC that was in effect for payment of RCC-based claims as of December 30, 2003[8].

It is important to note that this method of estimating cost, while commonly used in the industry for this type of analysis, has its limitations. The RCCs published and used by the State are based on all-payer data, i.e., the RCCs represent the ratio of aggregate allowable costs to aggregate allowable charges for all payers combined, including Medicare, Medicaid, commercial payers and the uninsured. To the extent that the utilization and mix of services may vary from payer to payer, and to the extent that they vary from claim to claim, these estimates may or may not reflect the actual costs of services provided. While this approach may result in a reasonable estimate of costs, these potential variations must be understood.

[8] Note that Washington Medicaid updates RCCs on a quarterly basis, and the quarterly update that was closest to December 30th of each year was effective in November of that year.

It is also important to note that, for purposes of this analysis, the RCCs used may result in an overestimate of costs. As described above, we used the RCCs in effect for payment purposes during the claim period. We did this to be consistent with the States RCC payment policy that assumes that these RCCs provide a reasonable estimation of costs for payment purposes. However, the State calculated these RCCs using cost report data from a prior period. In recent years, since hospitals charges have been increasing at a rate faster than costs have been increasing, the calculated RCCs have been trending downward. This may result in an overestimation of costs.

For example, as described earlier, we used the RCCs that were in effect for payments in December 2003 to estimate costs for SFY 2004 claims. These December 2003 RCCs were typically based on cost reports filed by the hospitals for either 2002 or 2003, depending on the hospitals' fiscal year end. Had the cost estimates been made using the RCCs that were in effect for the year following the data analysis period (but based on costs and charges more closely aligned with the data analysis period), it is likely that estimated costs would have been lower because the RCCs would have been lower.

It is also important to note that these analyses focus only on inpatient hospital services, which represent only a portion of the hospitals' operations. Outpatient hospital services, as well as hospice, home health, long-term care, and other specialized services, are excluded from these analyses. Similarly, this analysis focuses only on FFS operations, and does not address any services provided under the State's managed care programs.

Our data analyses of the Medicaid (Title XIX) FFS inpatient claims are described below, by report. For each report, we provide a brief description of the report, and our general observations. For the results of our analyses of GAU and LTAC claims data, please refer to Appendix D of this report.

Report 1: Summary Data by State Fiscal Year

Report 1 provides summary level comparisons of Medicaid (Title XIX) FFS net charges, payments, estimated costs and number of discharges for all hospitals combined for State Fiscal Years 2002, 2003 and 2004. The report also provides statistics for average net charge per discharge, average payment per discharge and average estimated cost per discharge. A summary of Report 1 is shown in Figure 2, on the following page. This report shows that net charges have increased in the aggregate at a significantly greater rate than both payments and estimated costs from SFY 2002 through 2004.

Figure 2

Washington State Medicaid
Inpatient Reimbursement System Study
Analysis of Medicaid Inpatient Paid Claims Data - SFY02 Through SFY04

Report 1: Summary Data by State Fiscal Year

Description	Net Charges [1]	Payments [2]	Estimated Costs [3]	Number of Discharges	Average Net Charge Per Discharge	Average Payment Per Discharge	Average Estimated Cost Per Discharge
	A	B	C	D	E=A/D	F=B/D	G=C/D
State Fiscal Year 2002	$ 870,714,414	$ 479,793,893	$ 500,255,578	72,010	$ 12,092	$ 6,663	$ 6,947
State Fiscal Year 2003	$ 965,739,810	$ 495,314,159	$ 546,437,421	71,753	$ 13,459	$ 6,903	$ 7,616
State Fiscal Year 2004	$ 1,175,832,406	$ 543,439,212	$ 590,386,024	74,113	$ 15,865	$ 7,333	$ 7,966
Percent Change SFY02-03	10.91%	3.23%	9.23%	-0.36%	11.31%	3.60%	9.62%
Percent Change SFY03-04	21.75%	9.72%	8.04%	3.29%	17.88%	6.22%	4.60%
Percent Change SFY02-04	35.04%	13.27%	18.02%	2.92%	31.21%	10.05%	14.67%

Notes:
(1) Net Charges are Total Claim Charges less Total Non-Covered Claim Charges. Total Non-Covered Claim Charges were less than .5 percent of Total Claim Charges.
(2) Non CAHs: Payments are the sum of DRG Allowed Charge amounts for DRG-based services, and Allowed Charge amounts for RCC-based services. These amounts represent the total payment amount to be received by the hospitals for these services, including all third-party payment amounts.
CAHs: Paid Claims data do not reflect cost settled payments for Critical Access Hospitals. For the purpose of this analysis, we assume Critical Access Hospital RCC Payments to equal Estimated Costs unless the hospital has AP-DRG payments. If a CAH has AP-DRG payments during the fiscal year, the AP-DRG payments and RCC payments are equal to the amounts reported in the paid claims data. RCC payments for Prosser in SFY 2002 do not include $78,450 returned to the State per the cost settlement process.
(3) Costs are estimated by multiplying a hospital's RCC by the net charges amount for each claim.

Data Sources:
Paid claims data provided by Washington State Medicaid for SFYs 2002, 2003 and 2004.
RCCs provided by Washington State Medicaid for SFYs 2002, 2003 and 2004.

Report 2: Summary Data by Peer Group

Report 2 provides summary comparisons at the Washington State Medicaid designated peer group level for State Fiscal Years 2002, 2003 and 2004. The report analyzes Medicaid (Title XIX) FFS net charges, payments, estimated costs and number of discharges (in the aggregate and separated by AP-DRG-based payment and RCC-based payment), as well as average per discharge amounts. This report also provides payments as a percentage of net charges and payments as a percentage of estimated costs statistics for each year.

Washington Medicaid currently uses six peer groups for rate-setting purposes. These peer groups are:

- Group A, rural hospitals;
- Group B, urban hospitals without medical education programs;
- Group C, urban hospitals with medical education programs;
- Group D, specialty hospitals or other hospitals not easily assignable to the other five groups;
- Group E, public hospitals participating in the "full cost" public hospital certified public expenditure program; and
- Group F, critical access hospitals.[9]

Figure 3, on the following page, shows which hospitals are assigned to each peer group.

Group D is made up of specialty hospitals, or hospitals that are not similar to the hospitals assigned to the other peer groups. It should be emphasized that the hospitals assigned to this peer group were not assigned because they were similar to one another, as is the case with the other peer groups. For example, Children's Hospital and Regional Medical Center is significantly different than Harborview Medical Center. The fact that they are included together as a peer group should not be construed as some indication that they are similar types of facilities.

[9] Washington Administrative Code 388-550-3300.

Figure 3: List of Hospitals By Peer Group

Specialty Hospitals:
Children's Hosp & Med Ctr-Seattle
Harborview Medical Center-Seattle
Mary Bridge Children's Hosp & Health Ctr -Tacoma
Oregon Health Sciences University Hosp-Portland
Seattle Cancer Care Alliance
St. Luke's Rehab Inst. - Spokane
Univ of Washington Med Ctr-Seattle

Urban w/MedEd:
Deaconess Med Ctr - Spokane
Eastmoreland General Hosp-Portland
Good Samaritan - Puyallup
Group Health Cooperative Central Hosp-Seattle
Legacy Emanuel Hospital - Portland
Legacy Good Samaritan Hosp - Portland
Northwest Hospital - Seattle
Overlake Hospital Med Ctr-Bellevue
Providence Portland Med Ctr
Providence St Peter Hospital - Olympia
Sacred Heart Med Ctr - Spokane
St Joseph Med Ctr - Tacoma
St Vincent Hosp Med Ctr-Portland
Swedish Medical Center (17th Ave)
Swedish Health Services (Broadway)
Tacoma General Allenmore Hospital
Valley Hosp Med Ctr - Spokane
Valley Medical Ctr - Renton
Virginia Mason Medical Ctr - Seattle
Yakima Valley Memorial Hosp

Urban w/out MedEd:
Auburn Regional Med Ctr
Capital Med Ctr-Olympia
Cascade Valley Hosp - Arlington
Central Washington Hosp-Wenatchee
Evergreen Hosp Med Ctr-Kirkland
Grays Harbor Community Hosp-Aberdeen
Harrison Memorial Hosp-Bremerton
Highline Community Hosp - Burien
Holy Family Hospital - Spokane
Island Hospital - Anacortes
Kadlec Medical Center - Richland
Kennewick General Hospital
Kootenai Med Ctr - Coeur D'Alene
Lourdes Medical Center - Pasco
Mason General Hosp - Shelton
Portland Adventist Med Ctr
Providence General Med Ctr-Everett
Skagit Valley Hospital
Southwest Washington Med Ctr-Vancouver
St Clare Hospital - Tacoma
St Francis Hosp-Federal Way
St John Medical Ctr - Longview
St Joseph Hosp - Bellingham
St Joseph Regional Med Ctr-Lewiston
St Mary Medical Ctr - Walla Walla
Stevens Memorial Hospital - Edmonds
Toppenish Community Hospital
Valley General Hosp - Monroe
Walla Walla General Hospital
Wenatchee Valley Medical Center
Woodland Park Hosp - Portland
Yakima Regional Medical & Heart Center

Rural:
Bonner General Hosp - Sandpoint
Columbia Memorial Hosp - Astoria
Good Shepherd Community Hosp-Hermiston
Gritman Medical Ctr - Moscow
Mid-Columbia Med Ctr - Dalles
Olympic Medical Center - Pt. Angeles
Providence Centralia Hospital
Providence Hood River Memorial Hosp
Samaritan Hospital - Moses Lk
Snoqualmie Valley Hospital
Whidbey General Hosp - Coupeville

Critical Access Hospitals:
Cascade Med Ctr - Leavenworth
Columbia Basin Hosp - Ephrata-
Coulee Community - Grand Coulee
Dayton General Hospital
Deer Park Health Ctr & Hosp
East Adams Rural Hosp - Ritzville
Enumclaw Memorial Hospital
Ferry County Memorial Hosp-Republic
Forks Community Hospital
Garfield County Memorial Hosp-Pomeroy
Jefferson General Hosp - Pt. Townsend
Kittitas Valley Community Hosp-Ellensburg
Klickitat Valley Hosp - Goldendale
Lake Chelan Community Hospital
Lincoln Hospital - Davenport
Mark Reed Hosp - McCleary
Mid-Valley Hospital - Omak
Morton General Hospital
Mount Carmel Hosp - Colville
Newport Community Hospital
North Valley Hosp - Tonasket
Ocean Beach Hosp - Ilwaco
Odessa Memorial Hospital
Okanogan-Douglas County Hosp - Brewster
Othello Community Hospital
Prosser Memorial Hospital
Pullman Memorial Hospital
Quincy Valley Medical Ctr
Skyline Hospital - White Salmon
St Joseph Hosp of Chewelah
Sunnyside Community Hospital
Tri-State Memorial Hosp-Clarkston
United General
Whitman Hosp & Med Ctr - Colfax
Willapa Harbor Hosp - South Bend

Psychiatric Hospitals:
BHC Fairfax Hospital - Kirkland
Lourdes Counseling Ctr - Richland
Puget Sound Behavior Health- Tacoma
West Seattle Psychiatric Hosp

LTAC Hospitals:
Kindred Hosp - Seattle
Regional Hospital - Seattle

Figures 4 though 10, on the following pages, graphically show some of the key trends from Report 2:

Figure 4

Analysis Of Hospital Medicaid (Title XIX) FFS Net Charges By Peer Group (SFY 2002-2004)

Figures in Millions

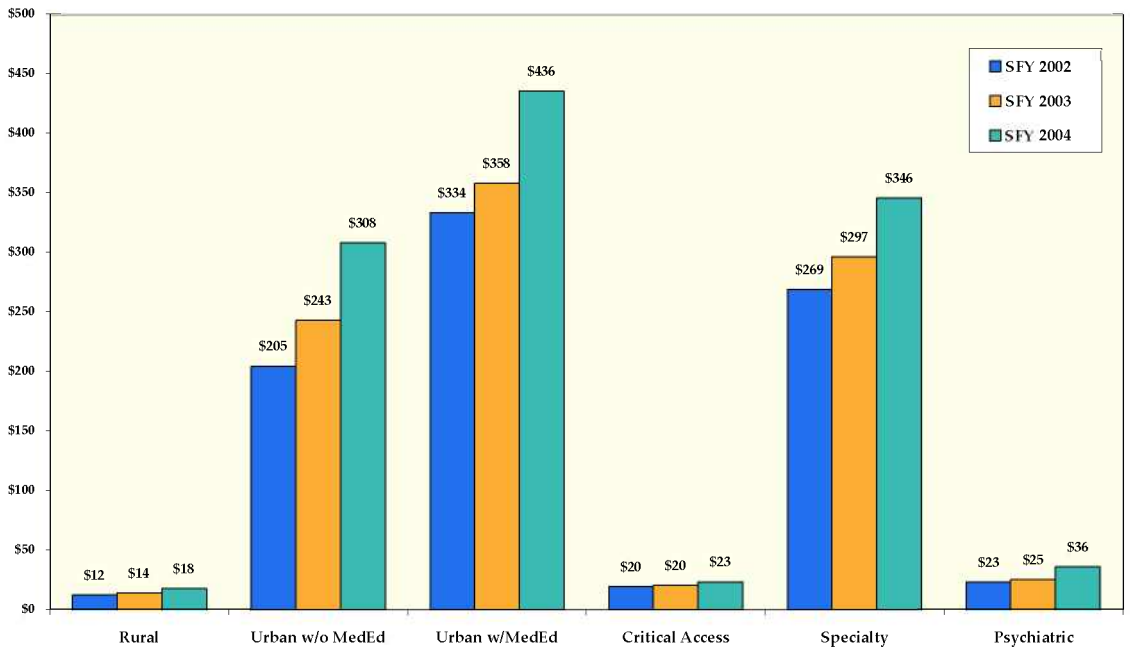
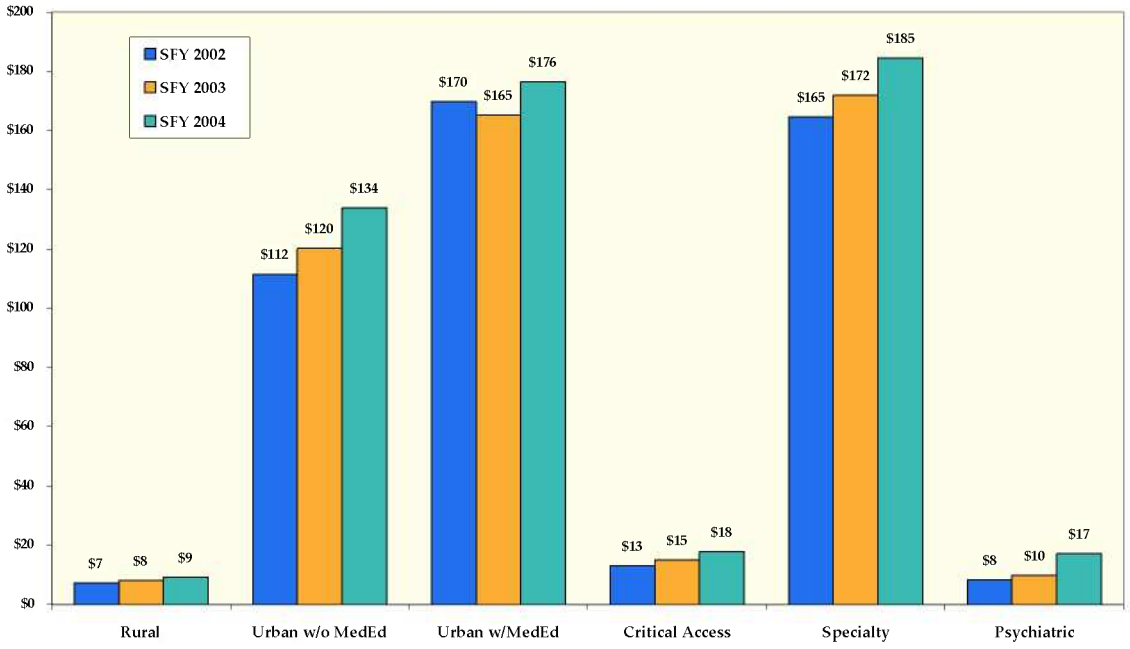


Figure 5

Analysis Of Hospital Medicaid (Title XIX) FFS Payments By Peer Group (SFY 2002-2004)

Figures in Millions



As discussed previously, the payments shown in Figure 5, above, are Medicaid (Title XIX) FFS payments only, and do not include any non-Medicaid State-only program payments. For psychiatric hospitals, it should be noted that non-Medicaid State-only program payments are generally lower than Medicaid payments for the same services. See additional discussion regarding psychiatric hospital payments in the Findings and Recommendations section of this report.

Figure 6

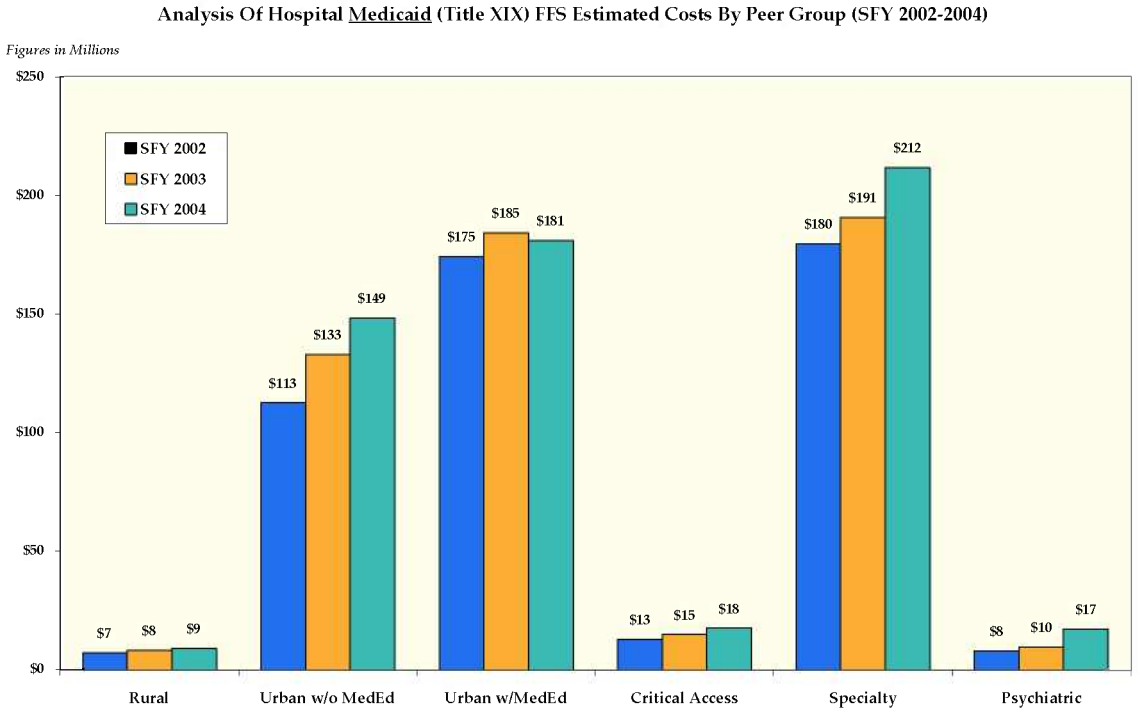
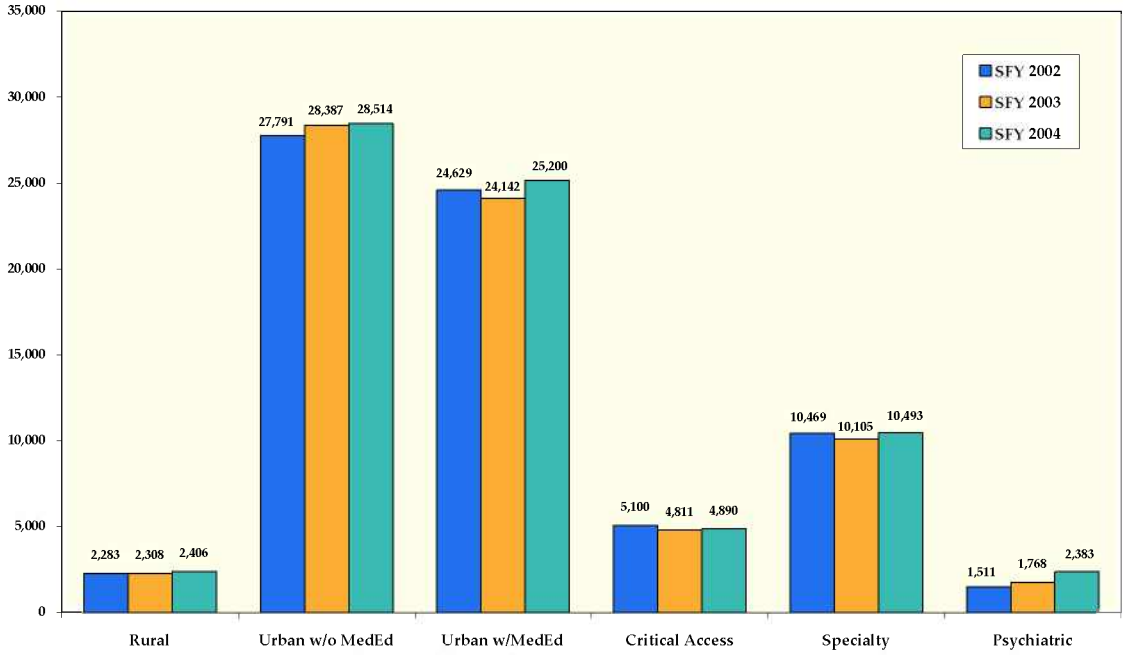


Figure 7

Analysis Of Hospital Medicaid (Title XIX) FFS Discharges By Peer Group (SFY 2002-2004)



Analysis Of SFY 2002 Medicaid (Title XIX) FFS Claims

Figure 8

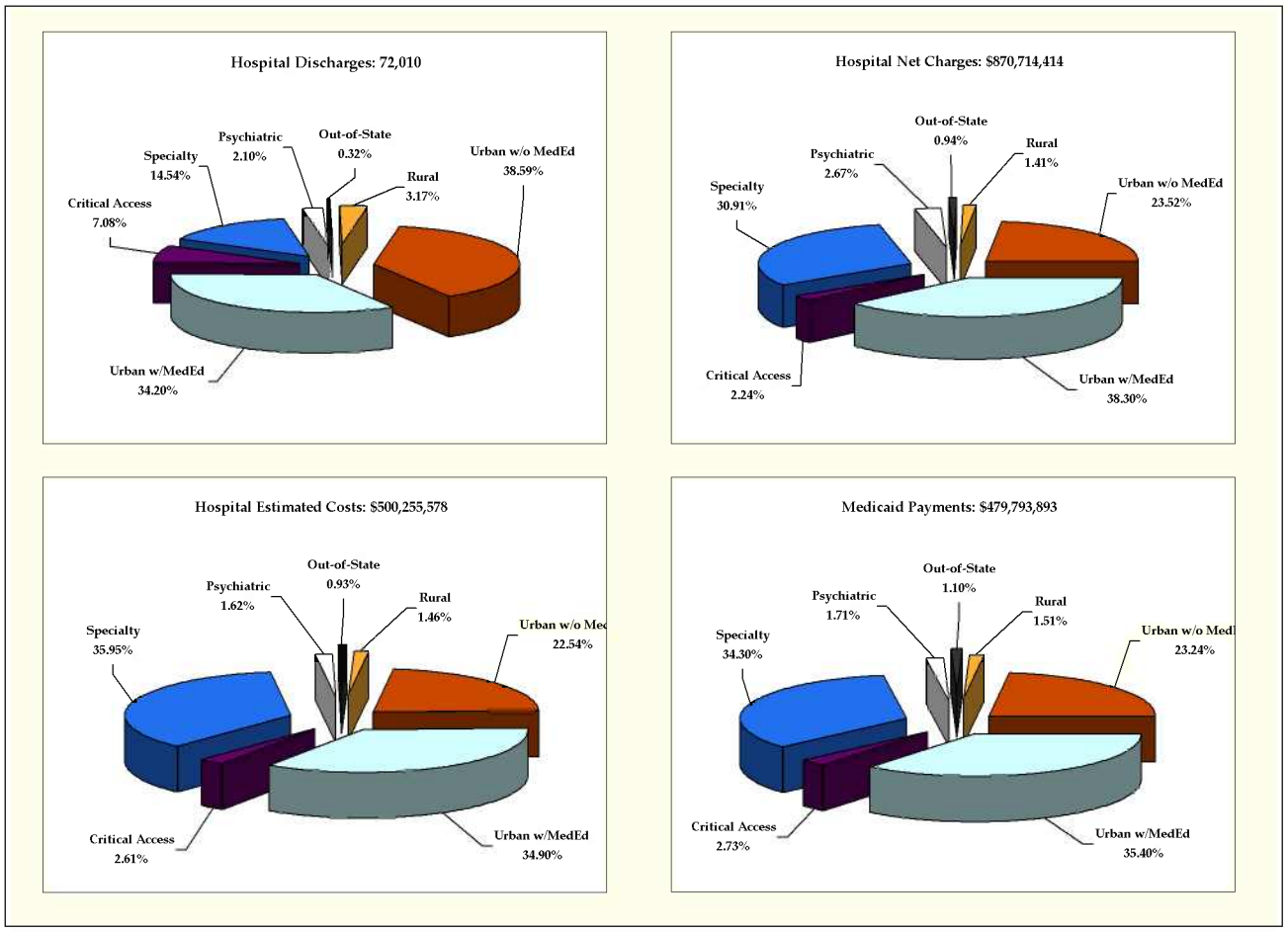
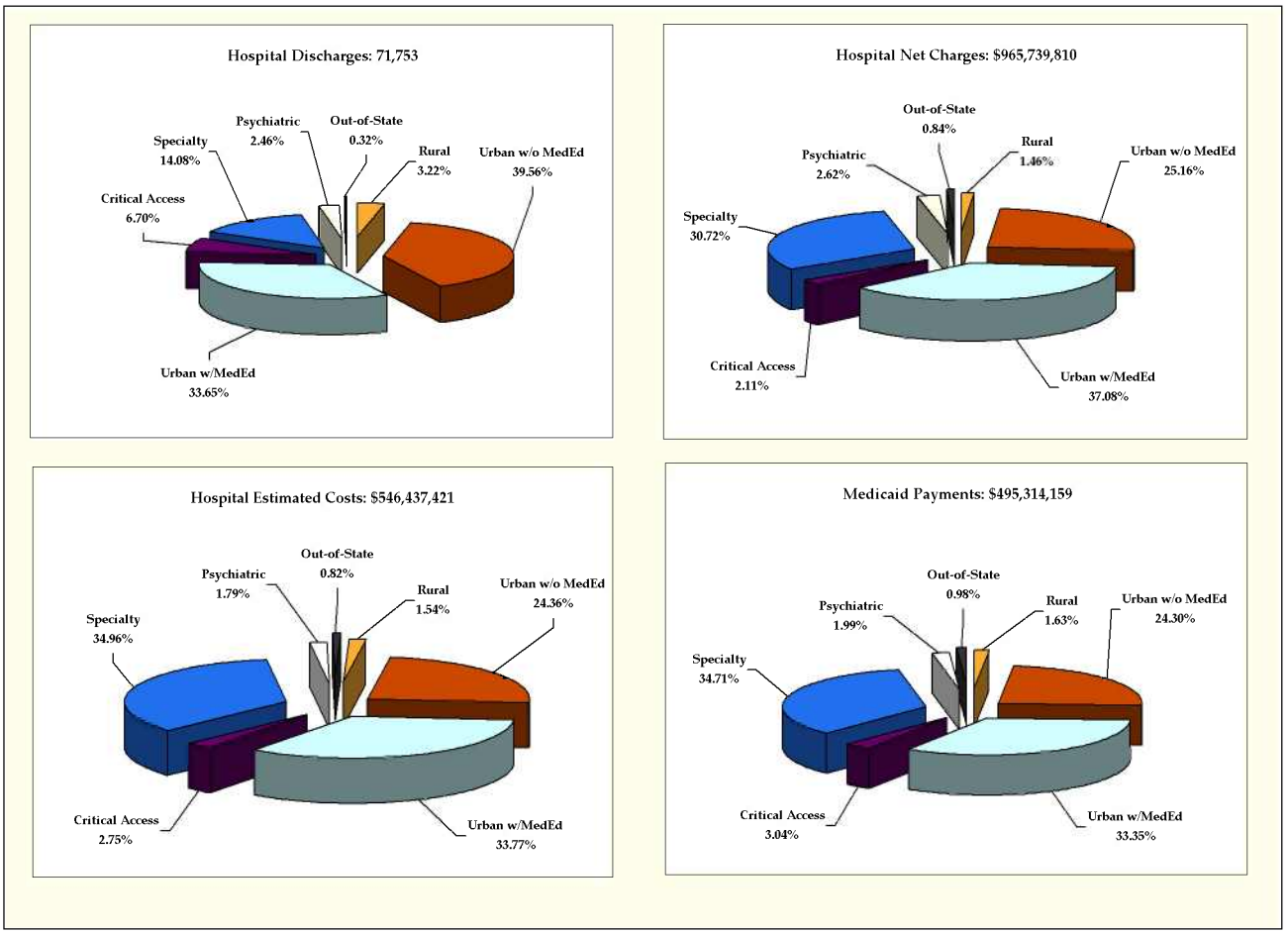
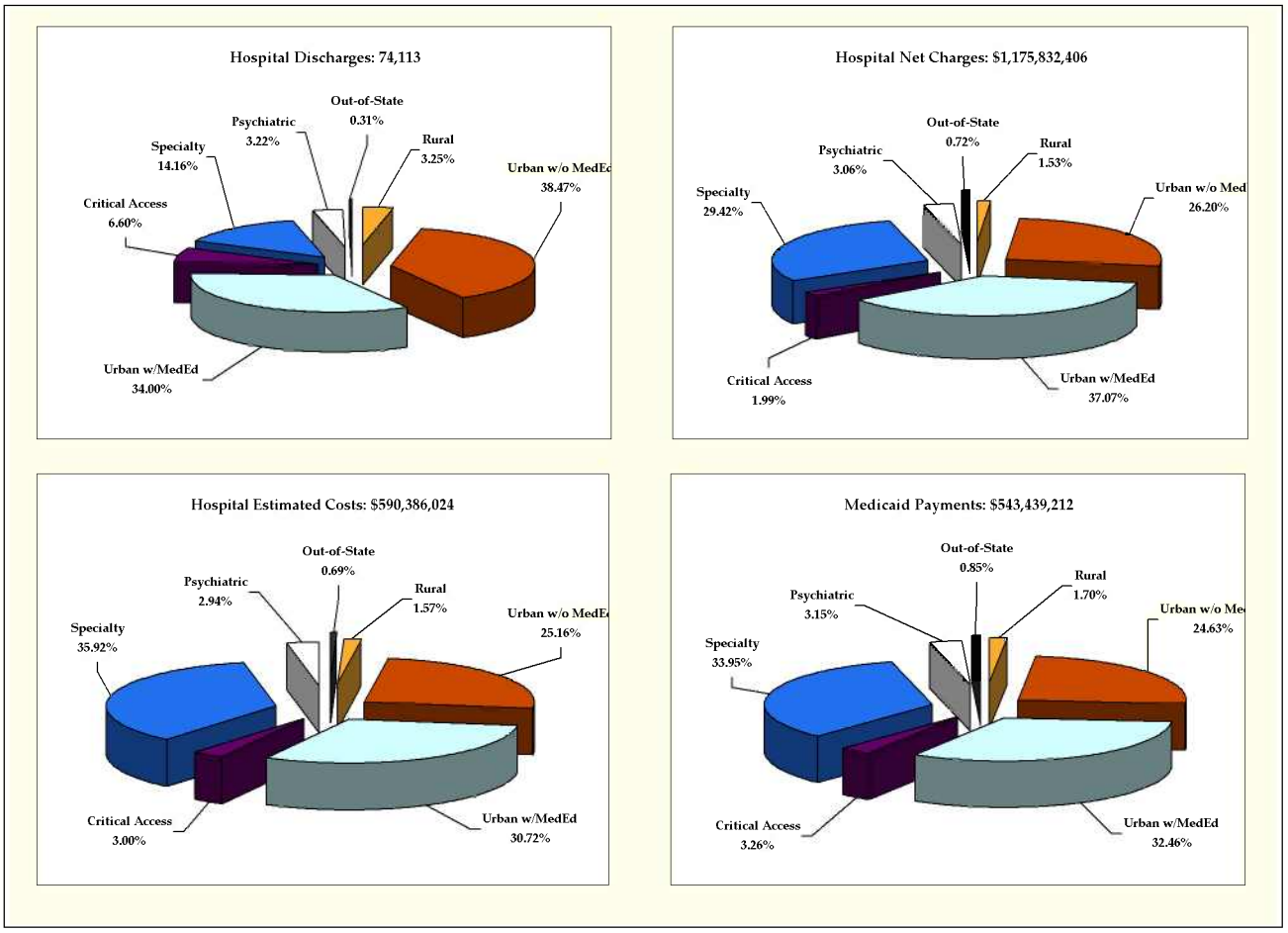


Figure 9


Hospital Discharges: 71,753
Psychiatric 2.46%
Out-of-State 0.32%
Specialty 14.08%
Rural 3.22%
Urban w/o MedEd 39.56%
Critical Access 6.70%
Urban w/MedEd 33.65%
Hospital Net Charges: $965,739,810
Out-of-State 0.84%
Psychiatric 2.62%
Rural 1.46%
Urban w/o MedEd 25.16%
Specialty 30.72%
Critical Access 2.11%
Urban w/MedEd 37.08%
Hospital Estimated Costs: $546,437,421
Out-of-State 0.82%
Psychiatric 1.79%
Rural 1.54%
Urban w/o MedEd 24.36%
Specialty 34.96%
Critical Access 2.75%
Urban w/MedEd 33.77%
Medicaid Payments: $495,314,159
Out-of-State 0.98%
Psychiatric 1.99%
Rural 1.63%
Urban w/o MedEd 24.30%
Specialty 34.71%
Critical Access 3.04%
Urban w/MedEd 33.35%

Analysis Of SFY 2004 Medicaid (Title XIX) FFS Claims

Figure 10



Consistent with Report 1, this report shows that net charges have increased at a significant rate during the data analysis period. It also shows that while the Urban with Medical Education peer group submitted claims with greater aggregate net charges than the specialty peer group for State Fiscal Years 2003 and 2004, the specialty peer group had higher estimated costs and received higher payments for the same periods.

Report 3: Analysis of Charges, Payments and Estimated Costs, by Hospital, by Peer Group

Report 3 provides comparisons of Medicaid (Title XIX) FFS net charges, payments and estimated costs, in total and average per discharge amounts, by hospital by peer group for State Fiscal Years 2002, 2003 and 2004. It also provides comparisons of payments to estimated costs and payments to net charges statistics.

For this report, Border Area Hospitals are shown along with all instate hospitals (Report 3a) and then again in a separate report (Report 3b).

This report allows for identification of significant changes in the above described statistics at the facility-specific level.

Report 4: Summary Data by Service Area, by State Fiscal Year

Report 4 provides comparisons of total hospital Medicaid (Title XIX) FFS net charges, payments and number of discharges for State Fiscal Years 2002, 2003 and 2004 by Health Information Program service area designation (or service line). This report also provides statistics for average net charge per discharge and average payment per discharge by service area designation.

The Health Information Program service line categories were developed in the State of Washington for use by the industry for analytical purposes. These service areas are defined by Medicare DRG classification. For purposes of this analysis, we developed similar definitions using the AP-DRG classifications. To do this, we started with the DRGs that were common to both patient classification systems, and adopted the service area designations for those classifications. With assistance from DSHS staff, we assigned the remaining AP-DRG classifications based on the type and nature of the service. See Appendix F for a crosswalk report that links each AP-DRG classification to one of the service area designations.

Report 4 shows that the most significant service areas based on payments were General Surgery, Neonatal, OB/Delivery, Orthopedic, Psychiatry and Pulmonary.

Report 5: Summary Data by AP-DRG, by State Fiscal Year

Report 5 provides comparisons of total hospital Medicaid (Title XIX) FFS net charges, payments and number of discharges for State Fiscal Years 2002, 2003 and 2004 by AP-DRG classification. It also provides statistics for average net charge per discharge and average payment per discharge.

Note that this report includes data for all discharges, including those discharges that are not paid based on the AP-DRG methodology.

This report can be referred to for purposes of understanding the distribution of payments by patient classification.

Report 6a: Analysis of Payments, by Type of Payment – Peer Group and Hospital Detail

Report 6a provides an analysis of the number of Medicaid (Title XIX) FFS discharges and payments by type of payment (AP-DRG-based payments including related outlier payments and RCC-based payments) for State Fiscal Years 2002, 2003 and 2004, by hospital and by peer group. This report also provides statistics for each year analyzing AP-DRG payments as a percentage of total payments, and RCC-based payments as a percentage of total payments, and how those percentages have changed over time.

This report shows that 32 percent of total payments were RCC-based payments in SFY 2004, and that this percent remained fairly constant in the data analysis period.

This report also shows that outlier payments as a percentage of DRG-based payments increased significantly during the data analysis period, from 9.7 percent in SFY 2002, to 13.7 percent in SFY 2004.

Report 6b: Analysis of Average Charge and Average Payment Per Discharge

Report 6b provides comparisons of average Medicaid (Title XIX) FFS net charges per discharge and average payments per discharge, by type of payment – AP-DRG discharges, outlier discharges and RCC discharges, for State Fiscal Years 2002, 2003 and 2004.

Report 6c: Analysis of Discharge Volume – Outlier Discharges
Report 6d: Analysis of Discharge Volume – Outlier Discharges – Peer Group Summary

Reports 6c and 6d provide analyses of the number of Medicaid (Title XIX) FFS outlier discharges compared to the number of AP-DRG discharges for State Fiscal Years 2002, 2003 and 2004. Report 6c presents this information by hospital, by peer group, and Report 6d provides this information at the peer group summary level.

These reports show that the number of outlier discharges has increased approximately 91.8 percent between State Fiscal Year 2002 and 2004, and that outlier discharges as a percentage of total AP-DRG discharges have increased from 3.3 percent to 6.1 percent for that period. These reports also show that this trend has generally occurred for all peer groups that are eligible for outlier payments.

Report 6e: Analysis of AP-DRG Inlier Average Payment Per Discharge
Report 6f: Analysis of AP-DRG Outlier Average Payment Per Discharge
Report 6g: Analysis of RCC Average Payment Per Discharge

This series of reports provides analyses, at the peer group level, of average Medicaid (Title XIX) FFS payments per discharge for AP-DRG inlier[10] claims, AP-DRG outlier claims and RCC-based claims. These reports show that the average payment for all payment types are significantly higher for the specialty hospitals than for all other peer groups.

Report 7: Analysis of Payments, by Type of Payment – AP-DRG Detail

Report 7 provides an analysis of the number of Medicaid (Title XIX) FFS discharges and payments by type of payment (AP-DRG-based payments including related outlier payments and RCC-based payments) for State Fiscal Years 2002, 2003 and 2004, by AP-DRG classification. This report also provides statistics for each year analyzing AP-DRG payments as a percentage of total payments, and RCC-based payments as a percentage of total payments, and how those percentages have changed over time.

This report provides a reference for understanding the statistics that were described previously at the AP-DRG classification level.

[10] Inlier claims are claims that are paid under the AP-DRG methodology, but do not meet the threshold to be considered outlier claims.

Report 8: Analysis of Discharge Volume

Report 8 provides a comparison of the number of total Medicaid (Title XIX) FFS discharges and transfer discharges for State Fiscal Years 2002, 2003 and 2004, by hospital and by peer group. It also provides statistics of transfer discharges as a percentage of total discharges. The total discharge analysis is shown in Report 8a. The transfer discharge analysis is shown in Report 8b.

This report shows that the utilization of inpatient hospital services, measured by inpatient hospital discharges, increased approximately 2.9 percent in the aggregate between SFY 2002 and SFY 2004. For the same period, it shows that transfer cases have increased approximately 5.7 percent.

Report 9: Analysis of Case Mix Index and Case-Mix Adjusted Average Charge Per Discharge

Report 9 provides a comparison of hospital Medicaid (Title XIX) FFS case-mix index, average net charge per discharge and case-mix adjusted average net charge per discharge for State Fiscal Year 2002, 2003 and 2004, by hospital and by peer group, for all claims paid under the DRG-based payment methodology.

This report shows that while the statewide Medicaid case-mix index has increased approximately 6.2 percent for the period from SFY 2002 to SFY 2004, the case-mix adjusted net charge per discharge has increased by approximately 28.4 percent for the same period.

Report 10: Hospital Utilization And Payment Overview

Report 10 provides an analysis for State Fiscal Years 2002, 2003 and 2004 of Medicaid (Title XIX) FFS payments, including AP-DRG-based Payments, RCC-based payments, Medicaid graduate medical education payments, Medicaid trauma payments and Disproportionate Share Hospital Payments, as well as estimated costs. It also provides a comparison of the number of Medicaid (Title XIX) FFS discharges to total (all-payer) hospital discharges. Data are presented by hospital, by peer group.

As described earlier in the data considerations section, the cost estimates used in this analysis are high-level estimates, and the reader is cautioned to take this into consideration when interpreting the results of this analysis. If we had applied more precise cost estimation techniques, the results could be different. Also, the costs included in this report are estimated costs of Medicaid (Title XIX) FFS claims only.

We considered the results of these quantitative analyses along with the results of our qualitative analyses for purposes of developing our Phase 1 recommendations. Our findings and recommendations are presented in the following section.

Phase 1 Project Findings and Recommendations

Generally, we found Washington State Medicaid's prospective payment system for inpatient hospital services to be a robust system that was carefully developed to address specific issues at the time it was designed. While we have identified some payment system features that are still effective and consistent with best practices, we found other features to be somewhat outdated and in need of modification.

In this section, as we discuss conversion factors, relative weights, per diem rates and other payment system components, we use the terms "update" and "rebase". For purposes of this study, we use the term "rebase" to describe the process of recalculating payment system components, such as conversion factors and relative weights, using more current data or other information. We use the term "update" to describe the process of revising conversion factors or other rate components to reflect increases mandated by the State Legislature or some other authority. The "update" is generally accomplished by applying authorized percentage changes to the rate components effective for the preceding year.

It is appropriate to "rebase" the payment system periodically, for example, once every three to four years, so long as a regular "rebasing" schedule is adhered to. Rate components should be "updated" in the interim years. This approach is commonly used by other States' Medicaid programs.

Our project findings are described in this section, by topic area. We also present, at the end of each topic's discussion, specific recommendations for improvement. As discussed earlier in this report, it should be noted that many of these recommendations are somewhat preliminary, and we have developed them without the benefit of a comprehensive fiscal impact analysis, which is anticipated as part of Phase 2 of this project. We do not believe that it would be appropriate, in most instances, to finalize our recommendations without fully understanding the fiscal impacts of the recommendations to the State, and to the individual providers in the State. As such, these recommendations should be viewed as options to consider further as part of the fiscal impact modeling in Phase 2. These recommendations will not become final until Phase 2 is completed.

We will finalize the recommendations in Phase 2 of this project, to a significant extent, based on the projected fiscal impacts to the State and the hospitals. As previously discussed, many, if not all of the recommended methodology changes will be interdependent. In other words, recommendations or methodology changes should not

be accepted or rejected individually. Making changes to some of the payment methodology features will be dependent upon other recommended changes. Accepting some, but not all recommended changes may result in unintended consequences, which might include not achieving budget neutrality, creating inappropriate incentives for providers and making payments that are not equitable.

Further, to the extent that the final Phase 2 recommendations are adopted, if our impact modeling identifies significant increases or decreases in projected payments to individual hospitals resulting from the methodology changes, the State should consider the appropriateness of phasing-in these recommendations over time.

For more details and additional discussion of the strengths and challenges of the current system, and to see examples of other states' approaches, please refer to the evaluation matrices in Appendix C of this report, and the state surveys in Appendix B of this report.

DRG Methodologies and Related Issues

Our study resulted in many findings and recommendations related to DRG-based payment methodologies and related issues. These are presented below, by sub-topic.

Use of the AP-DRG Grouper

Use of the AP-DRG grouper for classifying claims under the DRG-based payment methodology appears to be an appropriate design feature. The AP-DRG grouper is better suited for the Medicaid population because the grouper logic provides better classification of neonatal cases including consideration of birth weight data.

There are other innovative groupers available for consideration in payment systems, such as the All-Patient Refined DRG ("APR-DRG") grouper. However, it is our experience that the APR-DRG grouper has not yet been implemented by any Medicaid program for payment purposes. We have also conducted analysis related to the APR-DRG grouper that has indicated a high potential for claim upcoding that does not exist with either the AP-DRG grouper or the Medicare DRG grouper. To compensate for this, the hospitals would be required to exercise significantly more care in the coding of claims for billing purposes.

Washington Medicaid is currently using version 14.1 of the AP-DRG grouper[11], which is an outdated version of the AP-DRG patient classification model. While it still may be effective for classification of many types of cases, version 23.0 is currently available, and new versions will become available on a regular basis over time.

Comments received from the providers during the WSHA hospital stakeholder meetings support this recommendation. In recent meetings with hospital representatives, those representatives pointed out that there is a delay in how quickly new medical technology is reflected in the various grouper programs. Based on this comment, it would be logical to conclude that any delays in implementing newer versions of the AP-DRG grouper would tend to exacerbate this issue.

Calculation of Hospital Cost-Based Conversion Factors

For DRG-based payments, the State calculates conversion factors based on facility-specific costs using data submitted by the hospitals in their Medicare cost reports. The State's methodology for calculating costs for purposes of determining conversion factors is consistent with the methodologies used by other states in our survey.

Conversion factors are generally facility-specific, except that for the hospitals in the urban peer groups, the State limits the conversion factor to the 70th percentile of the adjusted cost basis amounts for each group. The State pays hospitals that are not subject to the cap using a facility-specific conversion factor. These facility-specific conversion factors may not provide the best incentive for the cost-effective delivery of services, because there is little opportunity to enhance margin or earn a profit by becoming more cost-effective. For example, if a hospital was able to actually reduce its costs, under the facility-specific approach, its conversion factor would also be reduced to reflect the lower costs.

A more effective approach would be the use of a standardized conversion factor that could be applied on a statewide or peer group basis. Such an approach would be consistent with many of the evaluation criteria described previously, as long as the State makes appropriate adjustments to the conversion factors to recognize cost differences associated with different provider types and locations.

[11] The AP-DRG grouper is a patient classification system developed and maintained by the 3M Company. Version 14.1 of the AP-DRG grouper was implemented by Washington Medicaid for payments effective January 1, 2001.

For example, if a standardized rate was used on a statewide basis, the State could adjust the conversion factor for regional wage differences by applying a wage adjustment to the labor portion of the conversion factor, similar to Medicare's approach (although we are not suggesting that the State adopt Medicare's rates). In addition, the State could apply adjustments to recognize cost differences associated with graduate medical education programs, trauma care capacity, neonatal intensive care capacity and other specialty services, such as those provided by children's hospitals[12]. Alternatively, peer groupings may be used to recognize appropriate cost differences for purposes of establishing peer group standardized conversion factors.

Based on input from the providers during an October WSHA advisory group meeting, the providers would embrace such an approach assuming that appropriate adjustments were made to the conversion factors described earlier.

It should also be noted that the State has not regularly updated or rebased the cost-based conversion factors. We suggest that the State establish a regular schedule for updating and rebasing conversion factors, along with relative weights and other payment system components.

Peer Groupings

For rate-setting purposes, Washington Medicaid assigns hospitals to peer groups. These peer groups have not been evaluated for some time.

Depending upon the methodology used to establish conversion factors in future periods, peer groups may not be necessary. On the other hand, realigned peer groups may serve as effective tools for making adjustments to conversion factors, and for establishing a basis for evaluating the adequacy of newly calculated conversion factors.

Services Excluded From The DRG-Based Payment Methodology

We also found that there are many services excluded from the DRG-based payment methodology that should not be excluded. It is our understanding that in many instances, specific services were excluded from DRG-based payment because at the

[12] We received significant comments from Children's Hospital and Regional Medical Center. Their representatives maintain that services provided by specialty children's hospitals should be excluded from DRG-based reimbursement. We believe that this issue should be addressed during Phase 2 of the project, and that if the resulting DRG-based payment model can be established in such a way that it provides for equitable payment for these specialty hospitals, other specialty hospitals and all other hospitals in the State, a DRG-based model may be appropriate.

time the system was designed, there were insufficient numbers of claims to support the development of relative weights for those specific services.

Excluding services from the DRG-based payment methodology is not uncommon. Many of the "core" states that we surveyed excluded some services, in particular psychiatric and rehabilitation services, and in some instances, transplant services. However, most other services were generally included under a DRG-based payment methodology.

Graduate Medical Education Costs

Under the current conversion factor calculation methodology for the urban peer groups, the State removes the estimated cost of indirect medical education before determining the 70th percentile cap. After adjusted cost per discharge amounts are compared to the cap, the State adds the costs of indirect medical education back to the conversion factor for payment purposes.

When Washington Medicaid rebased rates in past years[13], it used a formula based on the Medicare indirect medical education factor to estimate indirect medical education costs. Since the last rebasing, Medicare has made significant revisions to this factor. As such, the current factor is now outdated, and it would be appropriate for the State to modify its formula to reflect Medicare's changes.

Transfer Payments for DRG-Based Claims

For DRG-based claims, services provided to patients admitted as inpatients to an acute care hospital, who are then transferred to another acute care hospital, are paid by Washington Medicaid using a transfer payment policy. Payments in these instances are based on a pro-rata allocation of the DRG-based payment, based on the number of days the patient is in the transferring hospital.

The State calculates a per diem rate for this purpose by dividing the DRG-based payment amount by the statewide average length-of-stay for the DRG. The State pays the transferring hospital this per diem rate for the number of allowed days the patient is in the transferring hospital, not to exceed the full DRG payment amount. This policy does not apply to services provided in an outpatient or emergency department setting where the patient is not admitted as an inpatient.

While this approach recognizes some of the costs incurred by transferring hospitals, it does not recognize the higher intensity of services typically incurred in the early stages of a case required to stabilize a patient before transfer. Medicare addresses

[13] The last rebasing was effective for payments in January 2001.

this inequity by paying for an extra day in addition to the actual length-of-stay, and by using a geometric mean length-of-stay for the per diem calculation, which results in a larger per diem payment amount.

Recommendations for DRG Payments and Related Issues

For DRG Methodologies and Related Issues, we make the following recommendations:

- The State should update the version of the AP-DRG grouper that it is using. There are substantial improvements in the AP-DRG groupers developed after version 14.1. The most current version (version 23.0) should be implemented. In addition, the State should consider establishing a regular schedule for updating the AP-DRG grouper version, along with relative weights, conversion factors and other payment system components. Regularly scheduled updates would help to maintain the integrity of the system over time.
- The State should bring as many services as possible into the DRG-based payment methodology, to the extent that there are sufficient numbers of claims available to calculate stable relative weights. As discussed in the following sections, the State pays for significant volumes of services using other payment methods, and many of these services can be appropriately paid under the DRG-based methodology. The State also excludes provider types from the DRG-based methodology that could also be paid appropriately using this methodology.
- The State should reconsider the need to maintain peer groupings for purposes of establishing ceilings for payment purposes, and if necessary, evaluate peer grouping criteria to be consistent with other adopted methodology changes.
- The State should also consider whether peer group or statewide conversion factors could replace the current facility-specific approach. If adopted, such an approach should also consider the necessary adjustments to reflect appropriate differences in costs between providers, such as regional differences in wages, the costs of maintaining trauma programs, the costs of supporting graduate medical education programs, the costs associated with providing specialized children's services and high-risk neonatal services, and others.
- The State should consider modifying the indirect medical education factor used in cost calculations to reflect the most current Medicare-based formula.
- The State should analyze the costs of DRG-based transfer claims to determine if costs of services are more intensive in the first few days of a transfer. If so, the State should consider adjusting the transfer-out payment policy to better reflect the higher intensity of costs in the first few days of a patient's stay. For example, the state should consider following Medicare's approach of adding an additional

day of stay for purposes of calculating payment for the transferring hospital, or use 200 percent of the per diem for the first day.

Per Case and Per Diem Payment Methods

The State currently uses a per diem payment approach only for very limited services (for example, long-term care services and inpatient chronic pain services in selected hospitals, and administrative day services), and could expand the use of the per diem approach in some instances. We found that many states use per diem payments as a reasonable approach for paying for certain services, such as psychiatric and rehabilitation services. While the State currently pays for these services using the RCC methodology, we believe that a per diem approach may be more appropriate. This is addressed in more detail in the RCC Payment Methodology section, below.

For the Per Case and Per Diem Payment Methods, we make the following recommendations:

- Overall, the State should consider transitioning from its RCC payment approach and move to a prospective per discharge or per diem payment methodology for services currently paid under the RCC method.
- The State should consider a per diem approach for payment of psychiatric services, rehabilitation services, and acute services that are categorized into AP-DRGs that do not have enough historical claims volume to support the calculation of stable relative weights. The State should analyze the costs of providing psychiatric and rehabilitation services in freestanding psychiatric and rehabilitation hospitals, distinct part units and in acute care hospitals without distinct part units to identify variations and evaluate whether the variations should be accounted for in the per diem payment methodology.
- For new per diem services, the State should consider the need for a cost outlier policy. The State should conduct analyses during Phase 2 of the project to determine the significance of potential outliers.
- If the per diem methodology is expanded to more services, the State should consider implementation of concurrent utilization review and limitations on cost components (consistent with those adopted for the AP-DRG methodology, if applicable). To the extent that the utilization review functionality is expanded for related services, the State should also take into consideration the potential increased costs associated with such expansion.
- If the per diem methodology is expanded to more services, the State should consider adjusting the costs used for setting AP-DRG conversion factors to exclude the costs of services to be paid under the per diem methodology.

- The State should consider establishing a consistent schedule for updating and rebasing per diem rates. Updating and rebasing per diem rates should be done concurrently with updating and rebasing of all other payment system components, such as conversion factors.

Please refer to the discussion regarding psychiatric services for additional recommendations regarding the adoption of a per diem approach for psychiatric services. Also, please refer to the discussion regarding centers of excellence for more discussion of payment alternatives for transplant services.

RCC Payment Methodology

Our analysis shows that in 2004, 32 percent of all Medicaid (Title XIX) FFS inpatient hospital payments were made using the RCC payment methodology (see Report 6a in Appendix D of this report). This approach does not provide appropriate incentives for cost effectiveness, and allows the level of payments for any services paid under the methodology to be subject to changes in charges as determined by the hospitals. Hospitals can directly affect payments by simply increasing their charges for services provided.

Payments for RCC-based discharges have increased historically at a greater rate than the number of RCC-based cases. Our analysis shows that between SFY 2002 and 2004, the total number of Medicaid (Title XIX) FFS discharges paid under the RCC payment methodology increased by 655 discharges, or 3.8 percent. For the same period, RCC payments increased by approximately $18.5 million, or 11.9 percent (see report 6g in Appendix D of this report).

There are some instances where it may be appropriate to use an RCC methodology for payment purposes. For example, payments to critical access hospitals under this payment methodology may be appropriate on an interim basis, so long as a cost settlement is used to ensure that payments are equal to actual allowable costs at the end of each year. The use of RCCs is also appropriate and effective for estimating claim costs for purposes of identifying and paying for high cost outlier cases. However, Washington Medicaid's use of the RCC payment methodology extends significantly beyond these appropriate uses, and is also applied to neonatal services, psychiatric services, rehabilitation services, certain transplant services, all services provided by rural non-critical access hospitals, and others. We recommend a significant reduction in the use of RCCs for payment purposes.

The State's methodology for calculating facility-specific RCCs is sound. However, the State calculates the RCCs on a cyclical basis, once every quarter. In other words, the State calculates each hospital's RCC once a year, but at different times during the year. This is a time-consuming and administratively burdensome process for the

State, and it may not be necessary if less reliance is placed on the RCC payment methodology.

For the RCC Payment Methodology, we make the following recommendations:

- The State should consider eliminating the use of RCCs in most cases. Many services currently paid based on the RCC methodology could be paid based on the AP-DRG methodology, or a per diem methodology. Such a change would result in greater incentives for cost effectiveness, and enhance predictability of expenditures for the State.

Outlier Policy

High outlier payments are generally intended to provide additional payment for the extraordinary instances where the costs of a case are significantly higher than a typical case with the same DRG assignment. Since DRG payments are generally intended to pay the average cost of all claims in a particular DRG, outlier payments should be reserved for those extreme cases where the average payment is not sufficient.

Outlier payments as a percentage of DRG-based payments have increased significantly over the years. Between SFYs 2002 and 2004, Medicaid (Title XIX) FFS outlier payments as a percentage of DRG-based payments increased from 9.7 percent to 13.7 percent (see Report 6a in Appendix D to this report). This increase has occurred for several reasons. First, the State's outlier threshold has not been increased for some time, and as hospital charges increase each year, more cases are qualifying for outlier payment. Further, the current methodology for identifying outliers is based on charges, which results in a situation that allows providers to increase the number of outlier cases by simply increasing charges for services provided.

Our research of other states and Medicare shows that most states and Medicare make periodic adjustments to their outlier thresholds so that the cases that qualify for outlier payments are only those with extraordinarily high costs. Most states also identify outlier cases as those with estimated costs exceeding the outlier threshold, as opposed to those cases with charges exceeding the outlier threshold.

Washington Medicaid also makes use of a day outlier policy[14]. While day outliers were somewhat common a number of years ago when DRG systems were first being developed, most states and Medicare have subsequently discontinued the use of a

[14] For purposes of our trend analysis in Appendix D, we analyzed cost outlier claims only. We did not analyze day outliers.

day outlier feature. The current convention maintains that if the costs of a case do not merit special treatment under a high cost outlier policy, then the fact that a case has a long length-of-stay is not relevant for reimbursement purposes.

Also, the use of a facility-specific outlier set-aside pool may not be appropriate. Given the very nature of outlier cases where only the extraordinary cases should be considered, the nature and frequency of these types of cases may vary for individual hospitals from year to year. As such, it may not be appropriate to adjust conversion factors on a facility-specific basis.

For the State's Outlier Policy, we make the following recommendations:

- The State should consider eliminating the day outlier policy. If hospitals do not incur additional costs for outlier cases, normally, there is no need to pay for long lengths-of-stay[15].
- As discussed previously, the State should consider adopting a regular interval for updating the high-cost outlier threshold. There is also a need to regularly review the outlier policy to determine whether it is effective. Updates to the outlier policy could be made coincident with updates to conversion factors.
- The State should consider implementing a policy where the outlier threshold is set at a level so that only those cases with extraordinarily high cost are identified as outlier cases. This policy should be reevaluated on an annual basis.
- The State should consider implementing a policy where the outlier threshold is set at a level that results in a targeted outlier payment percentage of AP-DRG based payments, similar to CMS's policy for Medicare outlier payments. The threshold policy should be reevaluated on an annual basis so that resulting outlier payments remain within the States targeted amount.
- The basis for identifying outliers and determining outlier payments should be revised so that outliers are identified based on estimated costs and outlier payments are based on a percentage of estimated costs that exceed the outlier threshold (estimated costs determined by multiplying the RCC by the billed allowed charges). Under the current methodology, outliers are identified based on billed allowed charges, and outlier payments are based on a percentage of the billed allowed charges that exceed the outlier threshold. This leads to increases in outlier payments when a hospital increases its charges.
- The State should consider eliminating the facility-specific outlier set-aside amount. While it is important to consider and adjust the cost basis for

[15] Some states have maintained a day outlier policy for children's services to meet OBRA requirements. However, other states have successfully demonstrated that the use of cost outliers is sufficient to meet OBRA requirements without a separate day outlier policy.

conversion factors to reflect the costs of outlier claims, such adjustments could be accomplished at the statewide or peer group level. If the set-aside amount is retained, the calculation of the cost outlier set-aside amount should be modified to be consistent with revisions to the outlier payment policy. As described above, under the current policy, increases in charges tend to increase the outlier payments disproportionately. As a result, the set-aside amount tends to increase, thereby lowering the conversion factor, which in turn tends to further reduce the outlier threshold and increase outlier payments even more. The current methodology leads to ever-increasing levels of outlier payments.

Critical Access Hospitals

Recognition of critical access hospital ("CAH") status is consistent with the State's overall objective to maintain adequate access to hospital care in all regions of the State. Washington's criteria for the CAH designation is based on Medicare's designation, and is consistent with all of the "core" states in our survey.

A consistent theme related to CAH payments in all states that recognize CAH status is that the states' intent is to pay 100 percent of allowable costs for these hospitals, although in some instances, the states are precluded from this due to constraints placed on expenditures. But most states make the necessary adjustments to maintain full allowable cost reimbursement, even when other hospitals are being paid less than allowable cost. This arrangement is typically tolerated by other providers given that the aggregate funding for CAHs is generally such a small portion of total inpatient hospital funding. In Washington, total CAH Medicaid (Title XIX) FFS payments were 3.2 percent of total FFS payments made for Medicaid inpatient hospital services.

We found Washington Medicaid's CAH payment approach to be generally sound. Medicaid makes payments to CAHs on an interim basis using an RCC approach, which is intended to make payments based on the estimated cost of each claim. While the interim RCC payments may not precisely estimate the costs of each claim, we are not aware of any alternatives for interim payment of individual claims that would be practical from an administrative or payment perspective.

We did find, however, that Washington Medicaid performs two separate settlements for each year for CAHs; one on an interim basis, based on preliminary, or "as filed" cost reports, and another final settlement based on a final version of the cost report. Since individual claims are paid based on RCCs, it may not be necessary to perform an interim cost settlement.

Also, a significant issue brought forth by the CAH Stakeholder Group is worthy of discussion. It was pointed out that much of the financial viability of CAHs is

dependent upon not only inpatient hospital reimbursement, which is essentially at 100 percent of allowable cost. Other services, such as nursing facility, hospice and home health services are also a significant part of some CAH's activities, and to the extent that these services are paid for by the State at levels below allowable costs, these providers have a Medicaid shortfall in the aggregate.

For Critical Access Hospitals, we make the following recommendation[16]:

- The State should streamline the cost settlement process, and perform only one cost settlement. The current RCC methodology, if retained, should provide for sufficient reimbursement on an interim basis, until a final settlement can be completed. If a single cost settlement process is adopted, the State should consider allowing for exceptions in certain circumstances if a CAH can demonstrate that its costs are significantly different from the interim payments received.

Border Hospital Payment Methodology

Washington Medicaid pays for Medicaid services provided by out-of-state hospitals using different methods, depending on their location. If they are located in designated border areas, the State pays for their services using the same methodology used to pay for the same services to in-state hospitals. If out-of-state hospitals are outside of these designated border areas, the State pays for their services using a weighted average in-state RCC multiplied by billed allowed charges.

The border-area hospital designation was initially intended to ensure that appropriate services were available in all regions of the state, particularly in regions where Washington State Medicaid eligibles might need to cross the state border to receive necessary or specialized inpatient hospital services. However, the current policy, which designates hospitals as border-area hospitals based on location, does not consider the types of services provided by hospitals with that designation. In other words, there may be hospitals that are designated as border-area hospitals because of their location, but the services they provide are no different than the services provided by in-state hospitals within a reasonable proximity of a Medicaid client.

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[16] While some states such as Indiana and Virginia do not use cost settlement for CAHs and base payment solely on DRGs, we have not listed this as a recommendation due to the additional potential costs involved supporting the diseconomies of scale often found in CAHs. It should also be noted that commercial payers do not recognize a need for special payment to critical access hospitals.

Because of the border hospital designation, Washington Medicaid uses and maintains two separate out-of-state hospital payment methods. This approach may be unnecessary for purposes of maintaining appropriate access to care for Washington State Medicaid clients, particularly if similar services are available at in-state providers. Maintaining two separate payment methodologies may be unnecessarily burdensome from an administrative perspective, since all of the payment components necessary for in-state providers (i.e., conversion factors, outlier thresholds, RCCs, etc.) are also required for border area hospitals.

This approach could be simplified by establishing a policy for out-of-state payment based on rates and rate components from in-state hospitals, for example, an average of the conversion factors paid to in-state hospitals. For purposes of maintaining access to specialized services in certain border areas where such services are not available in-state, the State could continue to treat selected out-of-state hospitals using the in-state methodology. The State should limit this approach, however, to only those hospitals that are determined to be necessary for maintaining appropriate access to services.

For the Border Hospital Payment Methodology, we make the following recommendations:

- The State should re-evaluate the appropriateness of border hospital definitions, considering the access needs of Washington Medicaid clients relative to the provider services available in state, and those specific out-of-state hospitals that will enhance overall access to services.
    - For those hospitals identified as critical border-area hospitals in the above recommendation, maintain the current policy of payment based on the methodologies used to pay in-state providers.
    - For those hospitals identified as non-critical border-area hospitals, consider simplifying the payment methodology to make payments based on the same method used for in-state hospitals, using averages of in-state providers' rates (average conversion factors or per diem rates, which could be based on peer group designations, and average RCC for outlier payment determination). Amounts could be discounted if determined appropriate.
- For both non-critical and non-border-state hospitals, consider exclusion of payments related to medical education costs (direct and indirect).
- For out-of-state hospitals, consider exclusion of DSH payments. As part of the evaluation of this option, consider payment of DSH payments by other states to Washington hospitals.

Psychiatric Services

Washington has a federal waiver for all mental health services in the State. Under this waiver, county-based organizations known as Regional Support Networks ("RSNs") act as managed care entities to coordinate and manage mental health services for Medicaid eligible and state-only program clients. The intent of Washington's system is to have all publicly-funded mental health care in the State managed by the RSNs under full-risk capitation contracts, and Washington's federal waiver requires this for Medicaid clients.

In practice, however, the RSNs do not function like traditional managed care organizations for the inpatient hospital component of their clients' mental health services needs. The RSNs do not develop and maintain networks of participating hospitals to ensure that their clients have adequate access to inpatient mental health services. The RSNs also do not adjudicate hospital claims; they rely on the State to process claims, as well as to determine the payment methodology and rates for inpatient hospital services. Although the RSNs conduct prior authorization reviews for inpatient admissions and perform other utilization review functions, they do not know the full effect that their utilization review has on psychiatric hospital utilization because of their reliance on the State for the functions discussed above.

Other states have county-based managed care programs for mental health services, but Washington's dual system, which combines FFS inpatient mental health care under a managed care capitation arrangement, is unlike other states' Medicaid managed care programs with which we are familiar.

In response to the Washington Legislature's mandate, DSHS recently initiated a Request for Qualifications ("RFQ") for RSNs to demonstrate their qualifications to function as full-risk managed care organizations, including operating Prepaid Inpatient Health Plans for publicly-funded program clients. RSNs must submit their qualifications by December 1, 2005. DSHS will evaluate the responses during December 2005, and select qualified RSNs in January 2006[17]. On September 1, 2006 the selected RSNs are expected to begin operating as full-risk managed care organizations.

In evaluating the RSNs' responses to the RFQ, the State must carefully evaluate the RSNs' capabilities to fulfill this expectation as it relates to inpatient hospital services. Because of the many qualifications in the RFQ that the RSN must address, the scope

[17] If DSHS determines that an RSN does not have the necessary qualifications expected to fulfill the State's requirements as a full-risk managed care organization, the State will attempt to contract with other managed care organizations to provide this functionality in the RSNs service area. If the State is unable to contract with a qualified alternative, the State will revert to a FFS arrangement for payment of inpatient mental health services in the service area.

and significance of the responsibilities related to inpatient hospital services may not be fully appreciated. The WSHA has expressed concern about the prospect of RSNs paying inpatient hospital claims because it does not believe that the RSNs are equipped to do so. However, adjudicating inpatient hospital claims is only one component of the managed care organization function that the RSNs must be capable of fulfilling.

The RSNs must also have the capability to develop and maintain a network of participating hospitals to ensure that inpatient mental health services, including Involuntary Treatment Act services, are available to Medicaid and State-funded program clients, contract with network hospitals at negotiated payment rates and operate effective inpatient utilization management programs. These responsibilities are critical to the RSNs' ability to control their costs and maintain financial stability. The WSHA has also expressed concern about RSNs taking on full financial responsibility for managing inpatient services, because, unlike the Medicaid medical services managed care firms, the RSNs are not regulated by the State's Insurance Commissioner.

In addition to the issues associated with the RSNs transitioning to full-risk managed care organizations, there are two funding level issues related to inpatient mental health services that the State must consider. First, the State recently eliminated DSH payments for the four community freestanding psychiatric hospitals, because DSH payments to the state psychiatric hospitals account for the federally imposed maximum limit of 33 percent of the State's DSH allotment that can be paid to institutions for mental diseases. Thus, in effect, these four hospitals received rate reductions. Second, the State pays these hospitals less for state-funded programs, including Involuntary Treatment Act services, than for services hospitals provide to Medicaid clients. The State uses a ratio of cost-to-charge (RCC) methodology for services hospitals provide to Medicaid clients and pays for state-funded program services at a reduced RCC. Hospitals report that the payments they receive for providing inpatient mental health services to state-funded program clients cover only a small portion of their costs. It should also be noted that our analysis shows that there were 515 GAU discharges in SFY 2004 from psychiatric hospitals. This number has historically grown, and in SFY 2004, represents approximately 18 percent of the number discharges from psychiatric hospitals for Medicaid clients.

For Psychiatric Services, we make the following recommendations:

Our recommendations in this area are limited because of the current RFQ process. Depending upon the results of that process, it is our understanding that psychiatric services will either be provided under a full-risk managed care model, or remain under a fee-for-service arrangement. It is also our understanding that this decision may be determined on a regional basis, and that it is possible that in the end, there

may be a combination of models depending on the regional RSN capabilities. Understanding this, our recommendations focus on the potential for a fee-for-service model.

- The State should evaluate the best way to pay for inpatient psychiatric services if they revert to FFS in any of the regions. To accomplish this, the State should analyze the costs of providing psychiatric services in specialty psychiatric hospitals, distinct part units and in acute care hospitals without distinct part units to identify variations in costs and to understand the reasons for such variations. This analysis will support a determination as to whether there should be different methodologies based on the provider type (i.e., acute care hospital, distinct part unit, free-standing psychiatric hospital).
- The State should evaluate the feasibility of implementing a system based on Medicare's Inpatient Psychiatric Facility Prospective Payment System. Implementing a system based on Medicare's psychiatric and prospective payment systems would allow Washington Medicaid to pay for psychiatric services using a variable per diem approach that accounts for patient characteristics, such as age and comorbidities, that affect resource utilization. Concurrent utilization review would be necessary to assure that all days of a client's stay were medically necessary, but since per diem payment decreases as length-of-stay increases under the Medicare Inpatient Psychiatric Facility Prospective Payment System, the approach would create less incentive for longer lengths-of-stay. Also, as mentioned previously, the State should consider the potential additional cost associated with expanding the utilization review function related to this change.
- If the State determines that the Medicare approach is not appropriate, it should consider evaluating the implementation of a fixed per diem payment system with concurrent utilization review. The design of a fixed per diem payment system will depend on the results of the analysis recommended above[18].

Selective Contracting

Washington Medicaid's selective contracting program has been in place since 1988. Washington contracts with hospitals in certain urban areas of the State for inpatient hospital services they provide to Medicaid fee-for-service clients. In areas of the state where selective contracting is in effect, Washington Medicaid does not pay for

[18] Most commercial payers use a fixed per diem payment method for inpatient psychiatric services. A small number of commercial payers use a percentage of charge payment method for these providers.

non-emergent services provided in non-contracted hospitals unless the hospital is exempt from the selective contracting program. There are currently 25 contracting hospitals under this program[19].

Other than the public hospitals that participate in the CPE program, all in-state hospitals that are eligible (based on location) to participate in the selective contracting program participate in the program. By participating in the program, these hospitals agree to negotiate their conversion factors for fee-for-service DRG-based payment to an amount that is somewhat less than the hospitals' adjusted cost-based conversion factor. These negotiated conversion factors are publicly disclosed.

In theory, selective contracting arrangements are most effectively used to negotiate rates for only selected providers, and for selected services. Hospitals enter such contracts to receive discounted reimbursement under the presumption that they will be able to increase their market share in certain areas through restrictions placed on Medicaid clients that direct those clients to contracting hospitals for specific services. It is presumed that this approach results in lower expenditures for these specific services, not only through achieved discounting, but also because costs are generally lower through economies of scale[20].

We are aware of only one state that has effectively implemented and maintained such a program. California Medi-Cal has had such a program in place since 1982. California's program limits the number of hospitals participating in the program.

It is not clear that such savings have been achieved under Washington's current program. Medicaid has been able to achieve discounts in conversion factors paid to contracting hospitals, but since essentially all providers in selective contracting regions participate in the program and provide some discounting, there are no apparent advantages to this approach to managing conversion factor levels as opposed to other, more traditional, rate-setting methods.

Washington Medicaid should re-evaluate the selective contracting approach in the current environment. The full potential for cost savings resulting from a selective contracting approach will be difficult to achieve unless the State is willing to be more selective and limit the number of providers that can participate in the program. If

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[19] Prior to implementation of the State's CPE program, there were 31 contracting hospitals. Five public hospitals now participate in the CPE program, and are no longer part of the selective contracting program.

[20] Several commercial payers are expanding their use of selective contracting by not including high cost hospitals in their networks and by expanding pay for performance programs. In the future, there will be even greater involvement of commercial payers in selective contracting.

this type of limitation is incompatible with the State's current Medicaid strategy, it should consider discontinuing the selective contracting program.

For Selective Contracting, we make the following recommendation:

- The State should evaluate the need for selective contracting in the current environment and whether there are less administratively burdensome ways to achieve the State's health care access and cost containment goals. Consider discontinuing the Selective Hospital Contracting program.

Centers of Excellence

Washington Medicaid pays for transplant and bariatric surgery services for Medicaid clients only when these procedures are performed in hospitals that are designated as Centers of Excellence. To attain and maintain the Center of Excellence designation, the State evaluates hospitals using several criteria, including annual volume, patient survival rates and relative cost per case. Under the current program, Washington Medicaid pays these designated hospitals for transplant services using the RCC-based payment method, and for bariatric surgery services using a fixed case rate approach.

The Centers of Excellence approach may be an effective way of directing Medicaid patients to the most qualified providers for specific services. However, for purposes of achieving desired cost-effectiveness, there may be other, less administratively burdensome approaches.

Washington Medicaid should evaluate its objectives related to this program. If the intent is to direct care to the most qualified providers, the Centers of Excellence designation should be maintained. If it is maintained, the State should reconsider its payment approach, and consider expanding the fixed payment approach for more services, or negotiate a fixed rate or payment approach through a selective contracting arrangement, even in the absence of a more expansive selective contracting program.

If the designation is intended to achieve cost containment objectives, the State should consider discontinuing the program. There are other, more global approaches available to the State for purposes of achieving cost containment objectives.

For Centers of Excellence, we make the following recommendations:

- The State should evaluate the need for Centers of Excellence in the current environment and whether there are less administratively burdensome ways to achieve the State's health care access and cost containment goals. The State

should consider this issue in conjunction with the evaluation of the Selective Contracting program. If Selective Contracting is maintained, the Centers of Excellence program may be a way to better define those facilities that can participate in Selective Contracting.

- Consider adopting an alternative payment methodology for services currently covered under the Centers of Excellence program. For example, consider establishing fixed price payments for transplant services based on the payment levels currently in place for the Medicare program. Amounts could be adjusted to take into consideration the differences in resources between the Medicare and Medicaid population, and to meet the State's objectives for expenditures.

Trauma Care Program

Washington State makes supplemental trauma payments to hospitals that are intended to provide additional funding to hospitals to offset the high cost of operating and maintaining a statewide trauma care system. Trauma payments are made separately for Medicaid-related services, and for all other non Medicaid-related services.

Trauma care program funding is legislatively appropriated. Washington State Medicaid allocates the available Medicaid funding to Level I through Level III hospitals based on the hospitals' Medicaid reimbursement for inpatient and outpatient trauma care patients (based on predetermined Injury Severity Scores). The State allocates available non-Medicaid funding based on other criteria, and provides some funding to hospitals with Levels IV and V.

The current allocation methodology for trauma funding is not linked to the costs incurred by hospitals for purposes of maintaining their trauma service capacity. Medicaid should consider modifying its trauma allocations to link them more closely to the costs of providing services to trauma patients. The State should also convene a study to evaluate the non-Medicaid distribution of trauma funds to determine if the current allocation methodology is consistent with the overall trauma program objectives.

For Trauma Care Programs, we make the following recommendations:

As Washington's trauma care funding uses Medicaid and non-Medicaid funding as part of an overall strategy to support Washington's trauma care system, we have provided Medicaid-specific recommendations, but also considered non-Medicaid payments.

- The State should assess the extent to which total Medicaid payments for trauma services (DRG- or RCC-based payments and supplemental trauma care payments) cover estimated hospital costs over time.
- Washington Medicaid should collaborate with the Department of Health to conduct a study of uncompensated trauma care (Medicaid and other payers) to determine which trauma care providers (e.g., hospitals, physicians, ambulance providers and others) incur the greatest unreimbursed trauma care costs and use the results of this study to asses the current trauma care payment distribution (Medicaid and non-Medicaid) methodology.

DRG-Based Payments Exceeding 100 Percent of Billed Charges

As part of Phase 1, we were asked to evaluate the current Washington Medicaid policy that allows for DRG-based payments to be made in excess of allowed billed charges on a case-by-case basis. Some payers firmly believe that payments to hospitals should never exceed the amounts that are billed. Others believe that under a prospective per discharge payment methodology, like a DRG-based payment methodology, payments should be allowed in excess of charges to maintain the appropriate incentives for cost effectiveness.

Our surveys showed that the "core" states in our sample were split on this issue. Some states allow payments to exceed charges, and some states do not. Based on our consultants' collective experience across the country, the trend nationally is also split.

Theoretically, in a budget neutral system, amounts saved by limiting payments to billed allowed charges could be redirected to conversion factors or other rate components to benefit all providers in the system. We conducted a separate analysis to identify such potential for savings based on several scenarios.

We examined SFY 2004 Medicaid (Title XIX) FFS claims data, and identified the level of payments that exceeded various billed allowed charges thresholds. These are shown in Figure 11 below:

Figure 11: Payments Exceeding Billed Allowed Charges – SFY 2004 Fee-For-Service Claims[21]

Charge Threshold	Number of Discharges	Payments Exceeding Threshold
Payments Exceeding 100 % of Billed Allowed Charges	5,226	$15,347,388
Payments Exceeding 150 % of Billed Allowed Charges	1,604	$6,126,645
Payments Exceeding 200 % of Billed Allowed Charges	715	$2,920,089
Payments Exceeding 300 % of Billed Allowed Charges	190	$909,100

To further refine this analysis, we considered that there may be cases that are potentially incorrectly classified for payment. We analyzed the lengths-of-stay of these claims, with the understanding that claims that are categorized in high intensity AP-DRG classifications with very low lengths-of-stay (for example, one to two days) may be inappropriately classified for payment purposes. We examined all claims with payments exceeding 200 percent of allowed billed charges, and from that group of claims, identified claims meeting specific length-of-stay criteria.

For example, we found 232 claims that had payments of more than 200 percent of billed charges, and at the same time, had lengths-of-stay that were less than 20 percent of the statewide average length-of-stay for the AP-DRG classification. The total payments exceeding 200 percent of billed allowed charges for these claims were $1,666,313. All but 14 of these claims had lengths-of-stay of one or two days. This analysis is provided in Appendix E to this report.

For the policy allowing payments exceeding 100 percent of billed charges, we make the following recommendations:

- We do not recommend making a change to the payment methodology to limit payments to billed allowed charges. We believe that the potential for abuse of the current DRG-based payment system through inappropriate coding can be better addressed through other measures.
- The State should consider a policy that establishes a threshold, based on payments compared to billed charges, and based on length-of-stay; claims that exceed this threshold should be either suspended for payment and require a manual review, and potentially a medical record review by the

[21] Note that in total, there were 74,181 Medicaid FFS inpatient hospital discharges in SFY 2004, resulting in allowed payments of approximately $544 million.

State's Provider Review Organization prior to payment, or be flagged for review without suspension.

Conclusion

As mentioned previously, we found Washington State Medicaid's prospective payment system for inpatient hospital services to be a robust system that was carefully developed to address specific issues at the time it was designed. While we have identified some payment system features that are still effective and consistent with best practices, we found other features to be somewhat outdated and in need of modification.

It is clear in our evaluation that DSHS was very thoughtful in its development of the current system. Rates and relative weight calculations are well documented, and accurately determined. Significant detailed attention was given to all rates and rate component calculations.

Our recommendations focus primarily on potential changes to make the existing payment methodology and related rates more reflective of the current costs of providing services. This is not to suggest that payments are either adequate or inadequate, but that conversion factors, relative weights and other payment system components have not been updated for several years, and as more time passes, the relationship between payments and costs becomes less significant. Our recommendations also focus on potential changes that will make the system more prospective in nature, which if implemented, will make payments in future periods more predictable not only for the State, but for the providers.